

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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FOR STATE  
HEALTH DEPT.

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MEDICAL CERTIFICATION

MONTGOMERY COUNTY, MARYLAND											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN TB				d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH				5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
First Middle Last				Month Day Year							
S. SEX				6. COLOR OR RACE				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			
M ALE				WHITE				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
RETIRED								MARYLAND			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
CHARLES BARNES ABBOTT SR.				CARRIE RUSSELL				U.S.A			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Address			
YES				NAVY WORLD WAR I 578-03-8912				Wife Eliz. Jane Abbott (Same as above)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				Sudden							
4201				DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b)							
				DUE TO							
				(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
History of previous heart disease											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
Hour a.m. p.m.				19				(City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
ACTUAL SIGNATURE				M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				8-20-61			
22a. BURIAL, CREMATION, or REMOVAL (Specify)				22b. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or country) (State)			
Burial 8/23/61				Arlington National Cemetery				Arlington County Virginia			
23. FUNERAL DIRECTOR				24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE			
Raymond A. Ziska				8434 Georgia Avenue				Arthur L. Kraus			
Warner E. Pumphrey, Inc.				Silver Spring, Maryland				DATE AUG 25 '61			

595

~~CONFIDENTIAL~~

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9233

## CERTIFICATE OF DEATH

09223

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;"><u>MARYLAND</u></span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>17 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Montgomery</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> d. STREET ADDRESS <u>4704 Morgan Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Thomas</u> Middle <u>S</u> Last <u>Adams</u>		<b>4. DATE OF DEATH</b> Month <u>August</u> Day <u>28</u> Year <u>1961</u>		<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>March 24, 1902</u>		<b>9. AGE</b> (In years last birthday) <u>59</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Writer</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Associated Press</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Louisiana</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				<b>13. FATHER'S NAME</b> <u>Dr. Thomas S. Adams</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Helen Wilkins</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>429-09-8079</u>				<b>17. INFORMANT</b> <u>Mrs. Amanda Adams</u> <span style="float: right;">Address <u>As above</u></span> (Wife)				<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION, ACUTE</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>  </u> (c) <u>  </u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>  </u> p.m. <u>  </u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that (I) (the hospital) attended the deceased from</b> <u>AUG. 17, 1961</u> <b>to</b> <u>AUG. 28, 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>AUG. 28, 1961</u> <b>and that death occurred at</b> <u>5:09 P.M.</u> <b>from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <u>Leo M. Curtis</u> <span style="float: right;">M.D.</span>								<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <u>8218 Wisconsin Ave. Bethesda, Md</u>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Leo M. Curtis</u>								<b>22b. DATE SIGNED</b> <u>8-28-61</u>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial-Trans</u>				<b>23b. DATE THEREOF</b> <u>9/1/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Roselawn Cemetery</u>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey</u>				<b>ADDRESS</b> <u>Bethesda, Maryland</u>		<b>23d. LOCATION (City, town or county)</b> <u>Baton Rouge, Louisiana</u>		<b>25a. RECORD BY REGISTRAR</b> <u>AUG 30 1961</u>					
<b>25b. REGISTRAR'S SIGNATURE</b> <u>C. Lewis S. Evans</u>								<b>DATE</b>					

MEDICAL CERTIFICATION

0323

0323

8

1211 Wisconsin Ave. Washington, D.C.

Robert A. Murphy

Robert A. Murphy

Robert A. Murphy



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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9234

92224

079

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>52 minutes</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>2024 Powhatan Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Raymond Marlowe Ager</b>			4. DATE OF DEATH Month Day Year <b>August 8 1961</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 23, 1886</b>	9. AGE (In years last b. d. m.) <b>74 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		
13. FATHER'S NAME <b>Charles B. Ager</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>			14. MOTHER'S MAIDEN NAME <b>India Marlowe</b>		
16. SOCIAL SECURITY NO. <b>577-307570</b>			17. INFORMANT Address <b>J. Norman Ager - 6100 Ager Road, Hyattsville, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420 Ventricular fibrillation</b> DUE TO (b) <b>Acute Myocardial Infarct</b> DUE TO (c) <b>Coronary Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Several years</b>					INTERVAL BETWEEN ONSET AND DEATH <b>20 min</b> <b>2 hrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>MARCH 9, 1961</b> to <b>JULY 25, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 7, 1961</b> and that death occurred at <b>4:08 PM</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Raymond O. West</b>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>RAYMOND O. WEST</b>			22d. ADDRESS <b>WASHINGTON SANITARIUM</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Aug. 11, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEMETERY</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Malone</b>		25a. REC'D BY REGISTRAR <b>Aug 10 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Malone</b>	

(M)

Montgomery

Takoma Park

24 minutes Hyattsville

Maryland

Prince Georges

Washington Sanitarium & Hospital 3024 Potomac Road

Raymond Marlowe Ader

August 8

Male white

December 23, 1886

Former

Charles B. Ader

India Marlowe

Washington, D.C.

N. S. H.

Marlowe Ader - 6100 Ader Road, Mo.

Washington Sanitarium & Hospital  
3024 Potomac Road  
Washington, D.C.

Raymond Marlowe Ader

August 11, 1901

Washington Sanitarium & Hospital

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9235

## CERTIFICATE OF DEATH

04225

<b>1. PLACE OF DEATH</b> e. COUNTY <b>Montgomery</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>63 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		d. STREET ADDRESS <b>P. O. Box 15</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>BUSH</b> First <b>(none)</b> Middle <b>AINSWORTH</b> Last				<b>4. DATE OF DEATH</b> <b>August 30,</b> 19 <b>61</b> Month Day Year			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>February 24, 1897</b> 64 yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farmer-Carpenter</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farming-Carpentry</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Virginia</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>James M. Ainsworth</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Margaret E. Wiley</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>yes-WWI</b> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>218-18-0041</b> <b>17. INFORMANT</b> <b>The Medical Record</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Disseminated Histoplasmosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1. Staphylococcal Septicemia 2. Pulmonary tuberculosis; active</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 year</b>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from June 28, 1961, to August 30, 1961 that (I) (we) last saw the deceased alive on August 30, 1961, and that death occurred at 12:20 P.m. from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>William T. Butler</b>				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input checked="" type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/> <b>8/30/61</b>		<b>22b. DATE SIGNED</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>William T. Butler, M.D.</b>				<b>22d. ADDRESS</b> <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>9-2-61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Laytonsville</b>		<b>23d. LOCATION (City, town or county) (State)</b> <b>Laytonsville, Md.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Francis H. Barber</b>				<b>ADDRESS</b> <b>Laytonsville, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>SEP 5 '61</b>	
				<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur J. Knecht</b>			

(M)

(1)

Montgomery

Bedstead

The Clinical Center

Wash

(name)

ALBANY

August 30,

February 24, 1937

Wife

Male

James-Carpenter

James-Carpenter

Virginia

USA

James M. Almon

21-18-001

The Medical Record

not available The Clinical Center, Bethesda, Md.

see also

Discontinued Histopathology

1937

1. Ganglioneuroma of the adrenal gland; positive

June 28, 1937

12:30 P.M.

August 30, 1937

1937

x

The Clinical Center, National  
Institute of Health, Bethesda, Md.

William T. Butler, M.D.

9-2-61

Butler

Hyattsville

Hyattsville, Md.

Hyattsville, Md.

Hyattsville, Md.

TO HOSPITAL OR DURING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9236

## CERTIFICATE OF DEATH

09226

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>16 hrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>506 Gilmore Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>SALLIE LEE ALIMAN</b>		<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>10</b> Year <b>1961</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>June 1, 1883</b>
<b>9. AGE</b> (In years last birthday) <b>78 yrs.</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Cigar Rolling Machine Operator</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Virginia</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Nathaniel Thomas Allman</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Annie Wrenn</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>223-10-1224</b>	
<b>17. INFORMANT</b> <b>(Wellford Harrison) nephew-9404 Corsica Dr.</b>		<b>Address</b> <b>Beth, Md.</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO (b) <b>Coronary Thrombosis</b> DUE TO (c) <b>Coronary atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>20 hours</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>9 Aug. 1961</b> <b>to</b> <b>10 Aug. 1961</b> , that (I) <b>(was)</b> <b>last saw the deceased alive on</b> <b>10 Aug. 1961</b> , and that death occurred at <b>7:35</b> M, from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>Seruch T. Kimble</b>		<b>22b. DATE SIGNED</b> <b>10 Aug '61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Seruch T. Kimble</b>		<b>22d. ADDRESS</b> <b>927 Pershing Drive, Silver Spring, Md.</b>	
<b>22e. ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Aug. 14, 1961</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Parklawn Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Montgomery County, Maryland</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>WALTER E. PUMPHREY, INC., SILVER SPRING, MD.</b> <b>Raymond A. Ziska</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>16 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur J. Kline</b>			

02328

02328



Handwritten notes and stamps, including a date stamp '1945-10-12' and various illegible markings.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Wheaton, Md</b> c. LENGTH OF STAY IN 1b <b>Wheaton Nursing Home</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> D.C. b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>2916 Northhampton St. N. W.</b> d. STREET ADDRESS <b>Washington, D. C.</b> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Sadie</b> First Middle Last 4. DATE OF DEATH <b>August 28 1961</b> Month Day Year						5. SEX <b>Female</b> 6. COLOR OR RACE <b>white</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Feb 15/1886</b> 9. AGE (In years last birthday) <b>75</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Michael Trotsky, Russia</b>						14. MOTHER'S MAIDEN NAME <b>Rose Trotsky, Russia</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give year or dates of service)						16. SOCIAL SECURITY NO. <b>558-36-3241A</b> unknown		17. INFORMANT <b>Carl J. Alster</b> Address (see 2c & 2d)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Ca</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>4 mos</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <b>19</b>											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>MAY 1961</b> to <b>AUG 28 1961</b> , that (I) (we) last saw the deceased alive on <b>AUG 4 1961</b> , and that death occurred at <b>6:00 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Bernard H. Ostrow</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) <b>BERNARD H. OSTROW</b> 22d. ADDRESS <b>8107 EASTERN AVE SS MD</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>8/30/61</b> 23c. NAME OF CEMETERY OR CREMATORY <b>B'nai Abraham - Zion Cem.</b> 23d. LOCATION (City, town or county) (State) <b>Chicago, Ill.</b>											
24. FUNERAL DIRECTOR'S SIGNATURE <b>Isidore T. ...</b> ADDRESS <b>4217-92 St ...</b> 25a. REC'D BY REGISTRAR <b>AUG 29 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. ...</b>											

FOR HEALTH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR

STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
09228 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09228									
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>					c. LENGTH OF STAY IN 1b <b>3 days</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SUBURBAN</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>RAYMOND L. BAKER</b>					4. DATE OF DEATH <b>AUG. 9 19 61</b>				
5. SEX <b>Male</b>					6. DATE OF BIRTH <b>9/21/34</b>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. AGE (In years last birthday) <b>26</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Technical Arch.</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Labor Dept.</b>				
11. BIRTHPLACE (State or foreign country) <b>Rockville, Md.</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Raymond L. Baker Sr.</b>					14. MOTHER'S MAIDEN NAME <b>Grace Newman</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes Reserves</b>					16. SOCIAL SECURITY NO. <b>218-30 2788</b>				
17. INFORMANT <b>Brother Rudolph Baker (Same as above)</b>					Address <b>Rockville, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>825X Herniation of Brain Stem</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Intracerebral Edema</b> <b>Intra cerebral Hemorrhage</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>1 Day</b> <b>2 days</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a))									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of auto involved in accident</b>				
20c. TIME OF INJURY Month, Day, Year <b>10 p.m. 8-6 1961</b>					20d. INJURY OCCURRED <b>While at work</b> <input type="checkbox"/> <b>Not While at work</b> <input checked="" type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Ind R-28</b>					20f. (City or town) (County) (State) <b>Rockville Monty Md</b>				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Frank J. Brochart</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>Frank Brochart</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>8/11/61</b>				
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National.</b>					22d. LOCATION (City, town, or country) (State) <b>Arlington, Va.</b>				
23. FUNERAL DIRECTOR <b>Robert L. Snowden</b>					24a. REC'D BY REGISTRAR <b>AUG 14 '61</b>				
ADDRESS <b>Rockville, Md.</b>					24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneiss</b>				

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10/12/50

George Herman

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

<div>1</div> <div>9239</div> <div> <div>1</div> <div>M</div> <div>050</div> <div>I</div> <div>2</div> </div>											
<div>1</div> <div>9239</div> <div> <div>1</div> <div>M</div> <div>050</div> <div>I</div> <div>2</div> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY in 1b <b>9 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Scranton</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Scranton</b> d. STREET ADDRESS <b>1425 Crown Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>HAROLD JACOB BARKE</b>						<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>11</b> Year <b>19 61</b>					
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>June 26, 1924</b>		<b>9. AGE</b> (In years last birthday) <b>37</b> yrs. <div>             IF UNDER 1 YEAR              Months Days Hours Min.           </div>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Truck Driver &amp; Warehouseman</b>						<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Truck Driver &amp; Warehouseman</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Pennsylvania</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Jacob Barke</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Emma Mais</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>yes</b> <b>WW II</b>						<b>16. SOCIAL SECURITY NO.</b> <b>188-12-9427</b>		<b>17. INFORMANT</b> <b>The Medical Record</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aortic Insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Dilatation of Ascending Aorta</b> (c) <b>Marfan's Syndrome</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)						<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work Not While at work		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from August 2, 1961 to August 11, 1961 that (I) (we) last saw the deceased alive on August 11, 1961 and that death occurred at 2:05 PM from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <b>Harry R. Keiser M.D.</b>						<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>8-11-61</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Harry R. Keiser M.D.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>SHIP R.R.</b>						<b>23b. DATE THEREOF</b> <b>8-12-61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>SCRANTON PA</b>		<b>23d. LOCATION (City, town or county)</b> <b>SCRANTON PA</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W.W. Chambers Co Inc</b>						<b>ADDRESS</b> <b>1400 Chapin St NW Wash D.C.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>Aug 16 61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Kline</b>	

1953

1953

The Clinical Center  
 Bethesda  
 9 days  
 Pennsylvania  
 1157 Crown Avenue  
 August 11, 1953  
 37  
 June 20, 1953  
 USA

Jacob Lurie  
 108-12-2127 The Clinical Center, Bethesda, Md., Maryland  
 The Medical Record  
 from Lurie  
 Pennsylvania  
 USA

August 11, 1953  
 August 11, 1953  
 August 11, 1953  
 The Clinical Center, National  
 Institute of Health, Bethesda, Md., Maryland  
 August 11, 1953  
 August 11, 1953



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9240  
09230  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>?</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10420 Eastwood Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nathaniel Merritt Batchelor</u>				4. DATE OF DEATH <u>Aug 21 1961</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 4, 1907</u>		9. AGE (In years last birthday) <u>54</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>John Batchelor</u>				14. MOTHER'S MAIDEN NAME <u>Anna Lancaster</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give year or dates of service) <u>W War II</u>				16. SOCIAL SECURITY NO. <u>unobtainable</u>		17. INFORMANT <u>Decedent</u> Address <u>--</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyperkalemia</u> 451X DUE TO (b) <u>Renal failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Aortic aneurysm, dissecting, ruptured - post-op.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>34 hrs</u> <u>4 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>August 16, 1961</u> to <u>August 21, 1961</u> , that (I) (we) last saw the deceased alive on <u>August 21, 1961</u> , and that death occurred at <u>11:00</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Raymond Bradshaw, M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Aug 21, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw</u>				22d. ADDRESS <u>345 Univ. Blvd., W Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/23/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>The J.L. Hines Co.</u>				ADDRESS <u>Washington DC.</u>		REC'D BY REGISTRAR <u>AUG 22 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

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unclassified, secret

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5/23/61  
Washington DC  
Virginia  
111 111 111

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

9241

09231

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Monti</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>1801 Douglas Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <u>Linwood</u> Middle <u>A.</u> Last <u>Bell</u>		4. DATE OF DEATH		Month <u>Aug</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/25/09</u>		9. AGE (In years lost birthday) <u>52</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>individual</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Luther Bell</u>				14. MOTHER'S MAIDEN NAME <u>Clifford Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-10-0516</u>		17. INFORMANT <u>Sadie Bell</u>		Address <u>same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 2, 1958</u> to <u>8/21, 1961</u> , that (I) (we) last saw the deceased alive on <u>8/21, 1961</u> , and that death occurred at <u>7:20 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Stephen N. Jones</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/21/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stephen N. Jones</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>8/9/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul</u>		23d. LOCATION (City, town, or county) (State) <u>Deale, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Snowdon</u>				25a. REC'D BY REGISTRAR <u>Aug 7 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Carlton L. Kneiss</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10231

STATE OF CALIF.

10231

(M)

(T)

Attest: Secretary of State  
John G. Downey

Witness my hand and seal this 2nd day of July 1901

John G. Downey

Notary Public for the State of California

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. STREET ADDRESS	
Montgomery		Rockville		3 hrs.		12117 Otis Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Washington Sanitarium + Hospital							
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH		5. AGE (In years last birthday)	
Samuel Charles Berk				8 - 17		52 yrs.	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
Male		White				10 - 4 - 08	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Salesman		Insurance		Pennsylvania		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Jacob Berk				Lena Brown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
no		577-03 0124		Mrs Esther Berk		12117 Otis Dr Rockville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)				3 months			
1997X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b) Metastatic Carcinomatous Pulmonary adenomatosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8/16/61 to 8/16/61, that (I) (we) last saw the deceased alive on 8/16/61, and that death occurred at 12:45 AM, from the causes and on the date stated above.							
22a. SIGNATURE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
CHARLES M. WEBER, MD				12600 PARKLAND DR. ROCKVILLE-MD			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
BURIAL		AUG. 18, 1961		KING DAVID MEMORIAL GARDEN		FALLS CHURCH VA.	
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
B. Langensky + Sons				AUG 24 '61		Arthur S. Thomas	

00538

00538

(M)

Montgomery

James Park

Montgomery

Rockville

West of the Washington & Annapolis Road

2nd Ave

Clark

10-4-43

Shuman

Shuman

West Fork

Long Branch

1/2 mile from West Fork

1/2 mile from West Fork

1/2 mile from West Fork

CHARLES M. WELCH, JR.

CHARLES M. WELCH, JR.

CHARLES M. WELCH, JR.

CHARLES M. WELCH, JR.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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2

1

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9243  
CERTIFICATE OF DEATH  
09233

1. PLACE OF DEATH a. COUNTY Montgomery County, MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 812 Dunbarton Avenue	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Bernadette (MELLETT) BERRY		4. DATE OF DEATH Month Day Year August 20 19 61	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1921
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Joseph Mellett		14. MOTHER'S MAIDEN NAME Mary Flynn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Husband) Frank Hauthe Berry		Address 812 Dunbarton Ave., Baltimore, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 4 10 X Ventricular fibrillation DUE TO (b) Rheumatic Heart Disease mitral and aortic valve involvement Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hour 27 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial infarction			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 17, 1961, to August 20, 1961, that (I) (X) last saw the deceased alive on August 20, 1961, and that death occurred at 1:00 AM, from the causes and on the date stated above.			
22a. SIGNATURE L. N. CAHILL, LCDR MC USN		22b. DATE SIGNED August 20, 1961	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS U.S. Naval Hospital, NNMC, Bethesda 14, Md.	
23a. BURIAL, CREMATION, Removal and Burial		23b. DATE THEREOF 8-24-61	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. Stevens Funeral Home, Inc. 1501 E. FORT AVE.		25a. REC'D BY REGISTRAR AUG 23 '61	
		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

1950

1950

RECEIVED

(1950)

U. S. DEPT. OF JUSTICE

(1950)

RECEIVED

John Edgar Hoover

Director

John Edgar Hoover

Director

Very truly yours,

Respectfully,

Sincerely,

Sincerely,

Sincerely,

Sincerely,

Sincerely,

Sincerely,

Sincerely,

Sincerely,

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be examined within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09234

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORbeck</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORbeck</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>15015 Rosecroft Road.</u>		d. STREET ADDRESS <u>15015 Rosecroft Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Stewart</u> Last <u>Black</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>12</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 7, 1903</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>8</u> Hours <u>12</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>/</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CLARENCE THOMAS STEWART</u>		14. MOTHER'S MAIDEN NAME <u>HALLORAN, AGNES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-32-2316</u>	
17. INFORMANT <u>AGNES H. STEWART</u>		Address <u>15015 Rosecroft Rd, Norbeck</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the uterus.</u> DUE TO <u>174X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec - 1959</u> to <u>Aug - 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug 12 1961</u> and that death occurred at <u>9 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>William K. Ziegler</u>		22b. DATE SIGNED <u>Aug 12, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>William K. Ziegler</u>		22d. ADDRESS <u>202 Princess Anne Drive, Olney, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/16/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town, or county) <u>Washington D.C.</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond H. Ziska</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Hines</u>	
ADDRESS <u>Silver Spring, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	
25c. DATE <u>AUG 17 '61</u>		25d. ADDRESS <u>8434 Georgia Avenue</u>	

62524

CERTIFICATE OF DEATH

62524

(M)

(1)

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09235

1  
FOR STATE  
HEALTH DEPT.

9245

1. PLACE OF DEATH a. COUNTY: <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Rockville</u>			
c. LENGTH OF STAY in 1b <u>D.O.A.</u>				d. STREET ADDRESS <u>1119 S. Washington St</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Emily Yellott Blandford</u>				4. DATE OF DEATH Month Day Year <u>Aug 6 1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-1-1883</u>		9. AGE (In years last birthday) <u>78</u> yrs.	10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>				13. FATHER'S NAME <u>Deary W. Yellott</u>			
14. MOTHER'S MAIDEN NAME <u>Nannie Gittings</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT <u>John Elgin (Son-in-law)</u> Address <u>P.O. Box 483 Rockville, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Gastrointestinal Hemorrhage</u> 540.0 DUE TO (b) <u>Eroded Gastric Artery (Atherosclerotic)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Acute Gastric Ulcer</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Sudden</u> <u>Recent</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>8-7-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/9/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Church Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Towson, Maryland</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>				24a. REC'D BY REGISTRAR <u>Bethesda, Maryland</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3383

M

1

County of Baltimore

City of Baltimore

State of Maryland

Robert A. Pomphrey

Bethesda, Maryland

Tolson



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9246 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **09236**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> c. LENGTH OF STAY IN 1b <u>4 1/2 mo</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wheaton Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton Silver Spring</u> d. STREET ADDRESS <u>18812 Second Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Nannie Josephine Boland</u> First <u>Nannie</u> Middle <u>Josephine</u> Last <u>Boland</u>				<b>4. DATE OF DEATH</b> <u>Aug 4 1961</u> Month <u>Aug</u> Day <u>4</u> Year <u>1961</u>			
<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>1-17-1879</u> <b>9. AGE</b> (In years last birthday) <u>82</u> yrs.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Dep. Store</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>D.C.</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				<b>13. FATHER'S NAME</b> <u>Peter J. Boland</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Lydia Jenkins</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)			
<b>16. SOCIAL SECURITY NO.</b> <u>577-01-5444</u>				<b>17. INFORMANT</b> <u>Nursing Home Record</u> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <u>Carcinoma of sigmoid</u>  <b>DUE TO</b>            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b>  <b>DUE TO</b> <b>(c)</b> </div> <div style="width: 15%; text-align: center;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>mon. Flu</u> </div> </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> o. m. p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschert</u> <b>M.D.</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschert</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>8-4-61</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>XXXXXX</u>		<b>22b. DATE THEREOF</b> <u>8-7-61</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Cemetery</u>			
<b>22d. LOCATION (City, town, or county)</b> <u>Prince Georges Md.</u>		<b>(State)</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Warner E. Pumphrey, Inc.</u>		<b>ADDRESS</b> <u>8434 Georgia Ave., Silver Spring, Md.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>AUG 9 61</u>			
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hanna</u>		<b>DATE</b>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, & 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



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**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF BIRTH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>18 Takoma Pk</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>708 Phila. Ave. Cur-Len Nursing Home</u>		d. STREET ADDRESS <u>7216 Spruce Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Caroline Cooper Bowen</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-20-1876</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		9b. AGE (In years if UNDER 1 YEAR; last birthday) <u>84</u> yrs. Months <u>8</u> Days <u>4</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
13. FATHER'S NAME <u>Wm. R. MacFarlane</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Cooper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>Nursing Home Records</u>	
17. INFORMANT <u>Nursing Home Records</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4220.0</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arterio Sclerotic heart disease</u> (c) <u>Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>Months</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> e.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschazt</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCAZT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation Aug-3-61</u>		23b. DATE THEREOF <u>Aug-3-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fl. Lincoln</u>		23d. LOCATION (City, town, or country) (State) <u>Deabourburg Co. Prince Geo. Co.</u>	
23e. FUNERAL DIRECTOR <u>J. Arthur Walters</u>		23f. ADDRESS <u>254 Carroll St. N.W.</u>	
24a. REC'D BY REGISTRAR <u>AUG 3 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

**9248**

**09238**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> c. LENGTH OF STAY IN 1b <b>June-Aug. 1961</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>11,111 Lund Place</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>✓</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>NEW YORK CITY</b> d. STREET ADDRESS <b>200 W. 58th Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Annie Marie Bowman</b>		<b>4. DATE OF DEATH</b> Month <b>Aug</b> Day <b>17</b> Year <b>1961</b>		<b>5. SEX</b> <b>Female</b> <b>6. COLOR OR RACE</b> <b>white</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>12, 1880</b> <b>Sept. 10, 1880</b>			
<b>9. AGE</b> (In years last birthday) <b>80</b> yrs. <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>housewife retired</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Washington D.C.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>US</b>		<b>13. FATHER'S NAME</b> <b>John Bifield</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Annie Doyle Bifield</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> <b>16. SOCIAL SECURITY NO.</b> <b>---</b> <b>17. INFORMATION</b> <b>J. Lee Sugrue, 11,111 Lund Place, Kensington, Md.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pneumonia</b> DUE TO (b) <b>cerebral thrombosis</b> (c) <b>arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>10-15 yrs.</b>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>Congestive Heart Failure</b>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour a.m. <b>1300</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b> <b>June 16, 1961</b>		<b>20g. (County)</b> <b>Aug 17, 1961</b>		<b>20h. (State)</b> <b>1300 AM</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>June 16, 1961</b> <b>to</b> <b>Aug 17, 1961</b> <b>that (I) (we) last saw the deceased alive on</b> <b>Aug 16, 1961</b> <b>and that death occurred at</b> <b>1300 AM</b> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>Sanford J. Randall</b> <b>M.D.</b>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>8/17/61</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Dr. Sanford Randall</b>		<b>22d. ADDRESS</b> <b>8329 Grubb Rd. Silver Spring Md.</b>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>AUG. 19, 1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Olivet Cemetery</b>			
<b>23d. LOCATION (City, town or county)</b> <b>Wash. D.C.</b>		<b>23e. REC'D BY REGISTRAR</b> <b>AUG 21 '61</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Raymond A. Jaska</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>					

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TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9249  
CERTIFICATE OF DEATH  
09239

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>10</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital, Bethesda</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>102 Dawson Ave</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Boyd</u>		4. DATE OF DEATH <u>August 23 1961</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 21, 1961</u>		9. AGE (In years last birthday) <u>3</u> yrs. IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>Min.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Earl Luther Boyd</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Marie Howard</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Father (same as Above)</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYDROCEPHALUS &amp; MENINGOMYELOCELE</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>752X</u> (e), stating the underlying cause last. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>8-21-61</u> , 19 <u>61</u> , to <u>8-22-61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8-22-61</u> , and that death occurred at <u>8-22-61</u> M, from the causes and on the date stated above.															
22a. SIGNATURE <u>Robert D. Whithen</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>8-23-1961</u>							
22c. PHYSICIAN'S NAME (Type) <u>Bethesda</u>				22d. ADDRESS <u>md.</u>				22e. REC'D BY REGISTRAR <u>SEP 1 '61</u>				22f. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Aug 26, 61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville</u>				23d. LOCATION (City, town or county) (State) <u>Laytonsville md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis W. Barber</u>				ADDRESS <u>Laytonsville md.</u>				25a. REC'D BY REGISTRAR <u>SEP 1 '61</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

9250

09240

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN lb <b>5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47X-3</b> d. STREET ADDRESS <b>3545 Albemarle St., N. W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charles C. Bradley</b>		4. DATE OF DEATH Month Day Year <b>August 31 19 61</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/10/84</b>
9. AGE (In years last birthday) <b>77 yrs.</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wash. D.C</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Joseph Bradley</b>		14. MOTHER'S MAIDEN NAME <b>Mary Hooper</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes Army</b>		16. SOCIAL SECURITY NO. <b>Daughter Mrs. Lois Baker</b>	
17. INFORMANT <b>Address Kensington, Md</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Leukemia, myelogenous, acute</b> 204-3 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Cause unknown</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Acute gastro-enteritis</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>1950</b> to <b>Aug 31</b> , 1961, that (I) <del>(was)</del> last saw the deceased alive on <b>Aug 30</b> , 1961, and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Stewart Clapp</b>		22b. DATE SIGNED <b>9-31-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stewart Clapp M.D.</b>		22d. ADDRESS <b>4740 Chevy Chase Dr. Chevy Chase Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial 9/5/61</b>		23b. DATE THEREOF <b>9/5/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cem. Arlington Va</b>		23d. LOCATION (City, town or county) (State) <b>Arlington Va</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Cherry Chase Funeral Home</b>		25a. REC'D BY REGISTRAR <b>SEP 5 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Smith</b>		25c. DATE <b>SEP 5 '61</b>	

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3226

Joseph Bradley  
Born 1870  
Died 1910  
Buried in the  
Cemetery of  
St. Mary's  
Church  
New York  
City

St. Mary's  
Church  
New York  
City  
Buried in the  
Cemetery of  
St. Mary's  
Church  
New York  
City

9251

## CERTIFICATE OF DEATH

Reg. Dist. No.

09241

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laytonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laytonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rural</b>		d. STREET ADDRESS <b>Rural</b>	
3. NAME OF DECEASED (Type or print) <b>Martha J. Bradshaw</b>		4. DATE OF DEATH Month <b>August</b> Day <b>11</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 8, 1897</b>
9. AGE (In years last birthday) <b>63</b>		IF UNDER 1 YEAR Months <b>10</b> Days <b>3</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>UNKNOWN Charles Samuel Tudor</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Harriger</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Samuel Tudor-Same Item #2 Son</b>		Address <b></b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO <b>C-V.A.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO <b></b> (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b></b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8-11-61</b> , 19 <b>1958</b> , to <b>8-11-61</b> , 19 <b>1961</b> , that I last saw the deceased alive on <b>8-11-61</b> , 19 <b>1961</b> , and that death occurred at <b>7:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Gaithersburg, Md.</b> DATE SIGNED <b></b>			
ACTUAL SIGNATURE <b>Luciano J. Leal</b> M.D.		PHYSICIAN'S NAME (Type) <b>Luciano J. Leal</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-trans</b>	22b. DATE THEREOF <b>8/11/1961</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Taylor Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Falls Creek Pennsylvania</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>AUG 14 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Robert A. Humphrey, Bethesda, Maryland

Robert A. Humphrey, Bethesda, Maryland

Falls Creek, Pennsylvania

Robert A. Humphrey, Bethesda, Maryland

Falls Creek, Pennsylvania

Robert A. Humphrey, Bethesda, Maryland

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Robert A. Humphrey, Bethesda, Maryland

Falls Creek, Pennsylvania





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9253

## CERTIFICATE OF DEATH

09243

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN b. <b>30 MIN.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SYKESVILLE</b> d. STREET ADDRESS <b>GAITHER ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>BABY BOY "B" BROWN</b>		<b>4. DATE OF DEATH</b> Month <b>AUGUST</b> Day <b>18</b> Year <b>1961</b>	
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>AUGUST 18, 1961</b>
<b>9. AGE</b> (In years last birthday) <b>30</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>NEW BORN</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MONTGOMERY Co., MARYLAND</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>UNITED STATES</b>	
<b>13. FATHER'S NAME</b> <b>HERBERT EUGENE BROWN</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>MILLIE MARIE HAMILTON</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>	
<b>17. INFORMANT</b> <b>FATHER</b>		<b>Address</b> <b>ABOVE</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>769-9</b> DUE TO <b>Asphyxiation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prematurity, due to the twins</b> DUE TO <b>polyhydramnios of pregnancy.</b> (c) <b>3 1/2 months</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 1/2 months</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify that (I) (his hospital) attended the deceased from 8-18-61 to 8-18-61, that (I) (we) last saw the deceased alive on 8-18-61, and that death occurred at 8:15 A.M. from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>Sami Okutman</b>		<b>22b. DATE SIGNED</b> <b>8/18/61</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>A. S. OKUTMAN, M. D.</b>		<b>22d. ADDRESS</b> <b>SYKESVILLE, MARYLAND</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>8-18-61</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Roseview Memorial Park</b>	<b>23d. LOCATION (City, town or county) (State)</b> <b>Sykesville Carroll Co., Md</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Arthur S. Haight</b>		<b>25a. RECEIVED BY REGISTRAR</b> <b>DATE</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Haight</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9254

## CERTIFICATE OF DEATH

09244

<b>1. PLACE OF DEATH</b> a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 1 Mo.-7 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE Pennsylvania b. COUNTY Philadelphia c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Philadelphia 75X-3 d. STREET ADDRESS 202 E. Tioga Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																															
<b>3. NAME OF DECEASED</b> (Type or print) Pamela Lynn BUCK		<b>4. DATE OF DEATH</b> Month Day Year August 19 1961		<b>5. SEX</b> Female		<b>6. COLOR OR RACE</b> Caucasian		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> April 18, 1961		<b>9. AGE</b> (In years last birthday) yrs. 4 1		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Dependent Child		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> Pennsylvania		<b>11. BIRTHPLACE</b> (County & State, or foreign country) U.S.A.		<b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A.															
<b>13. FATHER'S NAME</b> Frank Edward BUCK						<b>14. MOTHER'S MAIDEN NAME</b> Dorothy Jennie ARNOLD																													
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) NO None						<b>16. SOCIAL SECURITY NO.</b> None						<b>17. INFORMANT</b> (Father) Frank Edward BUCK						<b>Address</b> 202 E. Tioga St., Philadelphia, Pa.																	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Conjunctive failure</i> 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Conjunctive Heart Disease</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 months																																			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. 19 <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State) 12 July 1961 to 19 August 1961																																			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from 12 July 1961 to 19 August 1961, that (I) <del>did</del> saw the deceased alive on 19 August 1961, and that death occurred at 7:55 PM from the causes and on the date stated above.																																			
<b>22a. SIGNATURE</b> <i>L. N. Cahill</i> M.D.										<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>				<b>22b. DATE SIGNED</b> 20 August 1961																					
<b>22c. PHYSICIAN'S NAME</b> (Type) L. N. CAHILL, LCDR MC USN										<b>22d. ADDRESS</b> U. S. Naval Hospital, NNMC, Bethesda, Md.																									
<b>23a. BURIAL, CREMATION, REMOVAL AND</b> (Specify) Burial-Shipment 21 Aug 1961						<b>23b. DATE THEREOF</b> 21 Aug 1961						<b>23c. NAME OF CEMETERY OR CREMATORY</b> Hillside Cemetery						<b>23d. LOCATION</b> (City, town or county) (State) Roslyn, Pennsylvania																	
<b>25a. REC'D BY REGISTRAR</b> DATE AUG 29 '61																		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. Kenna</i>																	

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF OHIO

1934

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Residence (Home)

1100 - 11th Ave

Philadelphia, Pa.

U. S. Naval Hospital

305 - 11th Ave

Phone

Room

Room

Occupation

1100 - 11th Ave

Residence (Home)

Philadelphia, Pa.

Franklin Square

1100 - 11th Ave

11

Room

(Mother) 1100 - 11th Ave

1100 - 11th Ave

1100 - 11th Ave

1100 - 11th Ave

1100 - 11th Ave

1100 - 11th Ave

1100 - 11th Ave

U. S. Naval Hospital

305 - 11th Ave

1100 - 11th Ave

1100 - 11th Ave

1100 - 11th Ave

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9255

## CERTIFICATE OF DEATH

09245

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>46 Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>8808 Lowell Street</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Paul Jeffrey Buck</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>August 23 1961</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>May 16, 1961</u>	
<b>9. AGE</b> (In years last birthday) yrs. <u>3</u>		<b>IF UNDER 1 YEAR</b> Months <u>3</u> Days <u>1</u>		<b>IF UNDER 24 HRS.</b> Hours <u>1</u> Min. <u>0</u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>District of Columbia</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Robert Max Buck</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret Valda Osburn</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>None</u>			
<b>17. INFORMANT</b> <u>Robert Max Buck</u>				<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart failure</u> <u>754.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Congenital heart disease (Tetralogy of Fallot)</u> (e), stating the underlying cause last. (c) <u>3 months</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> <u>May 16, 1961</u>				<b>20g. (County)</b> <u>Aug 23, 1961</u>			
<b>20h. (State)</b> <u>May 16, 1961</u>				<b>20i. (City or town)</b> <u>Aug 23, 1961</u>			
<b>21. I certify that (I) (the hospital)</b> attended the deceased from <u>May 16, 1961</u> to <u>Aug 23, 1961</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>Aug 1, 1961</u> , and that death occurred at <u>8-23-61</u> M, from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Harold M. Hobart</u>				<b>22b. DATE SIGNED</b> <u>8-23-61</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Harold M. Hobart</u>	
<b>22d. ADDRESS</b> <u>5402 CONN. AVE. NW. Wash. 15. DC</u>				<b>22e. REC'D BY REGISTRAR</b> <u>AUG 25 '61</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>burial</u>				<b>23b. DATE THEREOF</b> <u>8/25/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Ft. Lincoln Cemetery</u>	
<b>23d. LOCATION</b> (City, town or county) <u>Prince Georges, Md.</u>				<b>23e. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Finner</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The S.H. Hines Co.</u>				<b>24b. ADDRESS</b> <u>2901 14th St. NW. Washington, D.C.</u>			

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

<div style="display: flex; justify-content: space-between;"> <div> <p><b>MARYLAND STATE DEPARTMENT OF HEALTH</b> Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> </div> <div> <p><b>9256 MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b></p> </div> <div> <p><b>09246</b></p> </div> </div>																																															
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wood Acres</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wood Acres</b>																																									
<b>3. NAME OF DECEASED</b> (Type or print) <b>Kenneth Earl Buffin</b>						<b>4. DATE OF DEATH</b> <b>August 10, 19 61</b>																																									
<b>5. SEX</b> <b>Male</b>						<b>6. COLOR OR RACE</b> <b>White</b>																																									
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>						<b>8. DATE OF BIRTH</b> <b>July 10, 1888</b>																																									
<b>9. AGE</b> (In years last birthday) <b>73</b> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>						IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.																																		
IF UNDER 1 YEAR		IF UNDER 24 HRS.																																													
Months	Days	Hours	Min.																																												
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Colonel, U.S.A.</b>						<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Retired</b>																																									
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Williamsburg Virginia</b>						<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>																																									
<b>13. FATHER'S NAME</b> <b>John Buffin</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Margaret Smith</b>																																									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW1. &amp; WW2.</b>						<b>16. SOCIAL SECURITY NO.</b> <b>None</b>																																									
<b>17. INFORMANT</b> <b>Mrs. Florence A. Buffin</b> <b>5221 Massachusetts Avenue, Wood Acres, Maryland</b>																																															
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <table border="1"> <tr> <td colspan="12"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <b>Coronary Occlusion</b>  <b>420.1</b> DUE TO               </td> </tr> <tr> <td colspan="12"> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> </td> </tr> <tr> <td colspan="12"> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b> </td> </tr> </table>												<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Coronary Occlusion</b> <b>420.1</b> DUE TO												<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>												<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b>											
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Coronary Occlusion</b> <b>420.1</b> DUE TO																																															
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<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b>																																															
<b>19. WAS AUTOPSY PERFORMED?</b> <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>																																															
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>																																															
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)																																															
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19																																															
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>																																															
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)																																															
<b>20f. (City or town) (County) (State)</b>																																															
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																															
<b>ACTUAL SIGNATURE</b> <i>Frank J. Broschart</i> <b>M.D.</b>																																															
<b>EXAMINER'S NAME (Type)</b> <b>FRANK J. BROSCART</b>																																															
<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>																																															
<b>DATE SIGNED</b> <b>August 8, 1961</b>																																															
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>22b. DATE THEREOF</b> <b>8/14/61</b> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National Cemetery</b> <b>22d. LOCATION (City, town, or country) (State)</b> <b>Arlington, Virginia</b>																																															
<b>23. FUNERAL DIRECTOR</b> <b>Raymond A. Ziska</b> <b>ADDRESS</b> <b>Silver Spring, Maryland</b> <b>24a. REC'D BY REGISTRAR</b> <b>AUG 14 '61</b> <b>24b. REGISTRAR'S SIGNATURE</b> <i>William S. Thomas</i>																																															
<b>Warner E. Pumphrey, Inc., 8434 Georgia Avenue</b>																																															

MEDICAL CERTIFICATION

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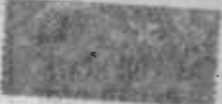
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

Item 20 Film 293 8-29-61 MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND Film 297 9257 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09247											
1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY in lb <u>26 hrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montgomery County Jail</u>						d. STREET ADDRESS <u>18 W. Montgomery Ave</u>					
3. NAME OF DECEASED (Type or print) <u>Sherman Lee Burke</u>			4. DATE OF DEATH Month <u>Aug</u> Day <u>17</u> Year <u>1961</u>			5. SEX <u>male</u>			6. COLOR OR RACE <u>white</u>		
5. SEX <u>male</u>			6. COLOR OR RACE <u>white</u>			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>9-12-1926</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Contractors</u>			11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Andrew Jackson Burke</u>						14. MOTHER'S M maiden name <u>Ida Light</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes. World War II</u>						16. SOCIAL SECURITY NO. <u>103-443-111</u>					
17. INFORMANT <u>Thornie W. Burk</u>						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Extracerebral Edema</u> 904.7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Subdural Hematoma Left</u> DUE TO (c) <u>Fractured Skull, Left Parietal Bone, Compound</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>UNTERMINED Fell</u>					
20c. TIME OF INJURY Month, Day, Year <u>3:30</u> p.m. <u>Unknown</u> 19 <u>61</u>						20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Co. Unknown/Jail</u>					
20f. (City or town) <u>Rockville</u>						20g. (County) <u>Mont</u>					
20h. (State) <u>Md.</u>						21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschant</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED <u>8-18-61</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>						22b. DATE THEREOF <u>8/19/61</u>					
22c. NAME OF CEMETERY OR CREMATORY <u>Sunset</u>						22d. LOCATION (City, town, or country) (State) <u>Christiansburg, Virginia</u>					
23. FUNERAL DIRECTOR <u>Tyson Wheeler</u>						24a. REC'D BY REGISTRAR <u>AUG 21 '61</u>					
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>						24c. ADDRESS <u>Funeral Home-1331 E. Montg. Ave. Rockville, Maryland</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

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9258  
MONTGOMERY  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
09248

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>21 days.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>36 Kensington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. STREET ADDRESS <u>12802 Jennings Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Mildred</u> Middle <u>M.</u> Last <u>CARPENTER</u>		4. DATE OF DEATH Month <u>August</u> Day <u>7</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 26 1914</u>
9. AGE (In years last birthday) <u>47</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jesse M. Hawley</u>		14. MOTHER'S MAIDEN NAME <u>Eva Bulkey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-38-279</u>	
17. INFORMANT <u>John C. Carpenter</u> husband		Address <u>same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infectious Glomerulo Nephritis</u> 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 yrs</u> <u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 7, 1961</u> to <u>August 7, 1961</u> , that (I) <u>met</u> last saw the deceased alive on <u>August 7, 1961</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Dewitt E. DeLawter</u>		22b. DATE SIGNED <u>8-8-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dewitt E. DeLawter, M.D.</u>		22d. ADDRESS <u>8025 ABERDEEN Rd. Beth., Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/10/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>		24. ADDRESS <u>Bethesda, Maryland</u>	
25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

*The End of the Road*

TO HOSPITALS OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9259

CERTIFICATE OF DEATH

09249

Item 1 Film G294 9/7/61 iwk

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Dist. of Columbia</u> COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> LENGTH OF STAY IN 1b <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethesda Suburban Hosp.</u>		d. STREET ADDRESS <u>4931-N. Capital. Apt. 24</u>	
3. NAME OF DECEASED (Type or print) <u>Enrico Joseph Carpentieri</u>		4. DATE OF DEATH <u>Aug. 25 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/14/16</u>
9. AGE (In years last birthday) <u>45</u>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cleaner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>private</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Vincent Carpentieri</u>		14. MOTHER'S MAIDEN NAME <u>Maria Riccone</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-18-184</u>	
17. INFORMANT <u>Adeline Carpentieri</u> Address <u>Same as Above.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Confluent bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (b) <u>Coma</u> (a), stating the underlying cause last. (c) <u>Cardiac Hemorrhage</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 20 4pm</u> , 19 <u>61</u> , to <u>Aug 25</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Aug 20</u> , 19 <u>61</u> , and that death occurred at <u>4pm</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>J.P. MURPHY, M.D.</u>		22b. DATE SIGNED <u>Aug 25 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>J.P. MURPHY, M.D.</u>		22d. ADDRESS <u>1904 R G hwy WASH. 9 DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/28/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Silver Spring, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Vincent</u>		25. REC'D BY REGISTRAR <u>Aug 28 '61</u>	
ADDRESS <u>525 Bladensburg Rd. N.E. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

9260

CERTIFICATE OF DEATH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09250

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENSINGTON GARDENS NURSING HOME</b>		d. STREET ADDRESS <b>2221 FOREST GLEN ROAD 1</b>	
3. NAME OF DECEASED (Type or print) <b>Mamie</b> First <b>MARYNNE</b> Middle <b>ELIZABETH</b> Last <b>CHEENEY</b>		4. DATE OF DEATH Month <b>AUG.</b> Day <b>4</b> Year <b>1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 28, 1888</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>File Clerk (Ret)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>	11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>
13. FATHER'S NAME <b>WILLIS CHEENEY</b>		14. MOTHER'S MAIDEN NAME <b>LOUISE MORTON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>2221</b> Address <b>FOREST GLEN RD. SILVER SPRING, MD.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL INFARCTIONS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CEREBRAL ATHEROSCLEROSIS</b> (c) <b>DIABETES MELLITUS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4-5 YRS.</b> <b>5-7 YRS.</b> <b>-</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CA COLON OPERATED 1955- NON CONTRIBUTORY</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>FEB. 22, 1958</b> to <b>AUG. 4, 1961</b> , that (I) (we) last saw the deceased alive on <b>AUG. 4, 1961</b> , and that death occurred at <b>7:50</b> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>James A. Roberts</b>		22b. DATE SIGNED <b>AUG. 4, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>JAMES A. ROBERTS</b>		22d. ADDRESS <b>8907 GEO. AVE. SILVER SPRING, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/7/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 9 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>		25c. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
9261											
09251											
1. PLACE OF DEATH a. COUNTY Montgomery						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)						c. LENGTH OF STAY IN 1b 4 Hrs & 13 Min					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital						e. STREET ADDRESS 6010 37th Ave.					
3. NAME OF DECEASED (Type or print) Timothy						4. DATE OF DEATH Month Day Year August 1 19 61					
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 1, 1961		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Mins 4 13	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Paul A. Chretien						14. MOTHER'S MAIDEN NAME Kathleen					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give number or date of service)		17. INFORMANT Paul A. Chretien Same as # 2 above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 770.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Erythroblastosis fetalis congenital											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (this hospital) attended the deceased from August 1, 1961 to August 1, 1961 that (X) (we) last saw the deceased alive on August 1, 1961, and that death occurred at 7:40 AM, from the causes and on the date stated above.											
22a. SIGNATURE Lawrence G. Thorne M.D.						22b. DATE SIGNED August 1, 1961					
22c. PHYSICIAN'S NAME (Type) Lawrence G. Thorne, LT MC USN						22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF August 4, 1961		23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION (City, town or county) (State) Fort Myer Va.	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers 5801 Cleveland Ave.						ADDRESS Riverdale, Md.		25a. REC'D BY REGISTRAR DATE AUG 3 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9262

CERTIFICATE OF DEATH

Reg. Dist. No.

04252

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ednor</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>1 2318 Wheaton, Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>BELMONT NURSING HOME</b>		d. STREET ADDRESS <b>x Ednor, Md</b>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>CLARK</b> Last <b>CLARK</b>		4. DATE OF DEATH Month <b>8</b> Day <b>2</b> Year <b>1961</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/1/1976</b>
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>2</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PHOTOGRAPHER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US GOVT.</b>	
11. BIRTHPLACE (State or foreign country) <b>MICHIGAN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ROBERT H. CLARK</b>		14. MOTHER'S MAIDEN NAME <b>EVA JACKSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NURSING + MEDICAL RECORD</b>	
17. INFORMANT <b>NURSING + MEDICAL RECORD</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLUS</b> DUE TO <b>CONGESTIVE HEART FAILURE</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (b) <b>RECENTLY POSTOPERATIVE (PROSTATECTOMY)</b> DUE TO (c) <b>TRANS VAGINAL HERNIA</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). <b>RECENTLY POSTOPERATIVE (PROSTATECTOMY)</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/9</b> , 19 <b>61</b> , to <b>8/2</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>7/31</b> , 19 <b>61</b> , and that death occurred at <b>11:25</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sandy Spring, Md</b> DATE SIGNED <b>8/2/61</b>			
ACTUAL SIGNATURE <b>John P Martin MD</b>		PHYSICIAN'S NAME (Type) <b>JOHN P MARTIN, MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>8/4/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George's County, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey, Inc.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 7 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9263

## CERTIFICATE OF DEATH

09253

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN TB <u>12 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>717 Ritchie Ave.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>717 Ritchie Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) <u>Sarah Emma Clark</u>		<b>4. DATE OF DEATH</b> Month <u>8</u> - Day <u>16</u> - Year <u>1961</u>		<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>August 21, 1884</u>		<b>9. AGE</b> (In years last birthday) <u>76</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>11. IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Montgomery County, Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>					
<b>13. FATHER'S NAME</b> <u>Mr. James Harvey</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Georgianna Goddard</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) <u>NONE</u>									
<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>				<b>17. INFORMANT</b> Address <u>Mrs. May A. Young 8623 Flower Avenue Takoma Park Maryland</u>													
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition</u> 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Chronic pyelonephritis</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinomatosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>Many years</u>																	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m. <u>  </u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>August 14, 1961</u> to <u>August 16, 1961</u>, that (I) <u>(no)</u> last saw the deceased alive on <u>August 14, 1961</u>, and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.</b>																	
<b>22a. SIGNATURE</b> <u>Bennet A. Porter, Jr.</u>				<b>22b. DATE SIGNED</b> <u>August 16, 1961</u>				<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Bennet A. Porter, Jr. M.D.</u>				<b>22d. ADDRESS</b> <u>9301 Colesville Rd., Silver Spring, Md.</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>8/19/61</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Fort Lincoln Cemetery</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>Prince George's County, Maryland</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Warner W. Pumphrey, Inc.</u>				<b>24a. ADDRESS</b> <u>8434 Georgia Avenue Silver Spring, Maryland</u>				<b>25a. REC'D BY REGISTRAR</b> <u>AUG 21 '61</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hanna</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Items 2, 11, 14 & 16 File # 3297 10/2/61 mh											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN lb <b>73 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>											
3. NAME OF DECEASED (Type or print) <b>Solly</b>				First <b>(None)</b>				Middle <b>Cohen</b>			
5. SEX <b>Male</b>				6. COLOR OR RACE <b>White</b>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Spotter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Dry Cleaning</b>				11. BIRTHPLACE (County & State, or foreign country) <b>New York Toronto, Can.</b>			
13. FATHER'S NAME <b>Issac Cohen</b>				14. MOTHER'S MAIDEN NAME <b>Bessie Schaaltes</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>562-12-9578</b>				17. INFORMANT <b>The Medical Record</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Respiratory arrest</b> DUE TO (b) <b>Widespread Epidermoid Carcinoma (Primary - left Alveolar ridge)</b> DUE TO (c) <b>Unascertainable</b> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. 144X INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>6 months</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3 days post-operative Medullary Tractotomy for Intractable Pain</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <b>May 31, 1961</b>				20g. (County) <b>August 12, 1961</b>				20h. (State) <b>9:15AM</b>			
21. I certify that (a) (this hospital) attended the deceased from <b>May 31, 1961</b> to <b>August 12, 1961</b> , that (b) (we) last saw the deceased alive on <b>August 12, 1961</b> , and that death occurred at <b>9:15AM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>J. Kent Trinkle</b>				22b. DATE SIGNED <b>8/12/61</b>				22c. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>			
22d. PHYSICIAN'S NAME (Type) <b>J. Kent Trinkle, M.D.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>AUG 15 1961</b>				23c. NAME OF CEMETERY OR CREMATOR <b>CHESED-SHEL EMMAFS</b>			
23d. LOCATION (City, town or county) <b>HILLSIDE</b>				23e. (State) <b>MD</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Daugerdy &amp; Sons</b>				24a. ADDRESS <b>3501-14th. NW.</b>				25a. REC'D BY REGISTRAR <b>AUG 24 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>											

9264

CERTIFICATE OF DEATH

09254

M

050

I

02334

02334

M

Montgomery

Patricia

73 days

The Clinical Center, Bethesda, Md.

3700 Rockledge Avenue

8017

(None)

Cohen

August

12

61

White

also

January 12, 1973

to

One cleaning

New York Times, etc.

Photo

Large corner

Board's building

The Clinical Center

University of Maryland, Baltimore, Md.

Cardiac Laboratory

Medical Research Center

(Primary - Left Atrial) etc.

Have post-operative laboratory for indurated skin

August 12

1973

12

August 12

8/12/73

The Clinical Center, National Institutes of Health, Bethesda, Md.

Montgomery, N.C.

Aug 12 1973

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9265

## CERTIFICATE OF DEATH

09255

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN lb <b>28 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> d. STREET ADDRESS <b>6710 Hillandale Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Persis C. Coiner</b>		<b>4. DATE OF DEATH</b> Month <b>Aug.</b> Day <b>19</b> Year <b>1961</b>					
<b>5. SEX</b> <b>female</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>4/26/1905</b>	<b>9. AGE</b> (In years last birthday) <b>56</b> yrs.	<b>IF UNDER 1 YEAR</b> Months <b>3</b> Days <b>19</b>	<b>IF UNDER 24 HRS.</b> Hours <b>3</b> Min. <b>19</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Housewife</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Washington, D. C.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>John Fairfax Conrad</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Martha Proudfit</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>none</b>		<b>17. INFORMANT</b> <b>Gordon C. Coiner-1732 East West Hgway.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peritonitis</b> DUE TO (b) <b>Perforated Appendicitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Ulcerative Colitis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Ulcerative Colitis</b>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from 7/22/1961, to 8/19/1961, that (I) (we) last saw the deceased alive on 8/19/1961, and that death occurred at 2:15 P.M. from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>Leon Gerber</b>		<b>22b. DATE SIGNED</b> <b>8/19/1961</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>LEON GERBER M.D.</b>			
<b>22d. ADDRESS</b> <b>1800 Eye St. N. W. Washington, D.C.</b>		<b>22e. REC'D BY REGISTRAR</b> <b>AUG 21 '61</b>					
<b>22f. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Hines</b>		<b>22g. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Hines</b>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>removal</b>		<b>23b. DATE THEREOF</b> <b>8/19/61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Ware Episcopal Cem.</b>			
<b>23d. LOCATION</b> (City, town or county) <b>Gloucester, Virginia</b>		<b>23e. (State)</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>The S. H. Hines Co.</b>		<b>ADDRESS</b> <b>Washington, D. C.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>AUG 21 '61</b>			
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Hines</b>		<b>25c. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Hines</b>					

MEDICAL CERTIFICATION

(M)

(1)

3253

00557

Montgomery

Montgomery

Bedstead

Cherry Chaise

Robinson Hospital

5710 Williamsdale Road

Table

Table

Temple White

in R/R 1902

Hospital

Hospital, D. C.

John Patrick Connelley

Marine Hospital

none

none

Peritonitis

Perforated Appendix

Ulcerative Colitis

2/19/34

12 1/2

8/12/1901

*[Signature]*

Leon

3253 & M.D. 1800 Eye St. N. W. Washington, D. C.

Removal 8/10/01

Wash Episcopal Cem. Gloucester, Virginia

The S. H. Hines Co. Washington, D. C.

412 21 St. N. W. Washington, D. C.

9266

## CERTIFICATE OF DEATH

Reg. Dist. No. 09256

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Washington D.C.</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kesmar Hospital</u>				d. STREET ADDRESS <u>417 E. Resenden St. N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Thomas</u> Last <u>Collins</u>				4. DATE OF DEATH Month <u>August</u> Day <u>16</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 7, 1877</u>	9. AGE (In years lost birth day) <u>84</u> yrs.	10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Banker</u>		11. BIRTHPLACE (State or foreign country) <u>Georgetown, Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Andrew Collins</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Ryan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-12-1079</u>		17. INFORMANT <u>Mrs. Jean H. Collins</u> Address <u>417 E. Resenden St. N.W. Wash. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 PNEUMONIA, BRONCHIAL</u> DUE TO (b) <u>PULMONARY EDEMA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>ARTERIOSCLEROTIC HEART DISEASE 10+ YEARS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ESSENTIAL HYPERTENSION</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>D. V. A.</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N.A.</u>		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/11/61</u> , 19 <u>61</u> , to <u>8/16/61</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>8/15/61</u> , and that death occurred at <u>9:05 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles J. Savarese</u> M.D.				ADDRESS (Street, city or town, state) <u>4890 BATTAYLA</u> DATE SIGNED <u>8/16/61</u>			
PHYSICIAN'S NAME (Type) <u>CHARLES J. SAVARESE MD</u>				BETHESDA, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>8/21/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Mt.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Chase Funeral Home</u> ADDRESS <u>5103 Wisconsin Ave N.W. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 21 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

0288

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH			
JAMES J. JONES		45		M		W		1880		NEW YORK			
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		DATE OF DEATH		PLACE OF DEATH			
1234 Main St.		Teacher		High School		Married		1925		New York			
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF ONSET		DATE OF EXAMINATION		PLACE OF EXAMINATION			
Heart Disease		Natural		6 Months		1925		1925		New York			
DETAILS OF CASE		HISTORY		PHYSICAL EXAMINATION		LABORATORY EXAMINATION		PATHOLOGICAL EXAMINATION		TREATMENT			
Patient had been ill for several months with heart trouble. He had been treated by a physician but had not improved.		On admission, patient was found to have a very weak heart. The lungs were normal. The kidneys were normal. The liver was normal. The spleen was normal. The stomach was normal. The intestines were normal. The bladder was normal. The prostate was normal. The testicles were normal. The penis was normal. The urethra was normal. The rectum was normal. The sigmoid colon was normal. The cecum was normal. The appendix was normal. The gallbladder was normal. The pancreas was normal. The duodenum was normal. The jejunum was normal. The ileum was normal. The cecum was normal. The appendix was normal. The gallbladder was normal. The pancreas was normal. The duodenum was normal. The jejunum was normal. The ileum was normal.		The patient was found to have a very weak heart. The lungs were normal. The kidneys were normal. The liver was normal. The spleen was normal. The stomach was normal. The intestines were normal. The bladder was normal. The prostate was normal. The testicles were normal. The penis was normal. The urethra was normal. The rectum was normal. The sigmoid colon was normal. The cecum was normal. The appendix was normal. The gallbladder was normal. The pancreas was normal. The duodenum was normal. The jejunum was normal. The ileum was normal.		The patient was found to have a very weak heart. The lungs were normal. The kidneys were normal. The liver was normal. The spleen was normal. The stomach was normal. The intestines were normal. The bladder was normal. The prostate was normal. The testicles were normal. The penis was normal. The urethra was normal. The rectum was normal. The sigmoid colon was normal. The cecum was normal. The appendix was normal. The gallbladder was normal. The pancreas was normal. The duodenum was normal. The jejunum was normal. The ileum was normal.		The patient was found to have a very weak heart. The lungs were normal. The kidneys were normal. The liver was normal. The spleen was normal. The stomach was normal. The intestines were normal. The bladder was normal. The prostate was normal. The testicles were normal. The penis was normal. The urethra was normal. The rectum was normal. The sigmoid colon was normal. The cecum was normal. The appendix was normal. The gallbladder was normal. The pancreas was normal. The duodenum was normal. The jejunum was normal. The ileum was normal.		The patient was found to have a very weak heart. The lungs were normal. The kidneys were normal. The liver was normal. The spleen was normal. The stomach was normal. The intestines were normal. The bladder was normal. The prostate was normal. The testicles were normal. The penis was normal. The urethra was normal. The rectum was normal. The sigmoid colon was normal. The cecum was normal. The appendix was normal. The gallbladder was normal. The pancreas was normal. The duodenum was normal. The jejunum was normal. The ileum was normal.		The patient was found to have a very weak heart. The lungs were normal. The kidneys were normal. The liver was normal. The spleen was normal. The stomach was normal. The intestines were normal. The bladder was normal. The prostate was normal. The testicles were normal. The penis was normal. The urethra was normal. The rectum was normal. The sigmoid colon was normal. The cecum was normal. The appendix was normal. The gallbladder was normal. The pancreas was normal. The duodenum was normal. The jejunum was normal. The ileum was normal.	



TO HOSPITAL OR HOSPITAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

BP

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
09257													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>-</u> b. COUNTY <u>-</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON D.C.</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON D.C.</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RESMOR HOSPITAL + SAN.</u>						d. STREET ADDRESS <u>1821 SUMMIT PL N.W.</u>							
3. NAME OF DECEASED (Type or print) <u>MARY HOWARD CORBETT</u>						4. DATE OF DEATH <u>AUGUST 27 1961</u>							
5. SEX <u>F</u>						6. COLOR OR RACE <u>W</u>							
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>AUG 26 1871</u>							
9. AGE (In years last birthday) <u>90</u> yrs.						10. IF UNDER 1 YEAR <u>90</u> Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>							
11. BIRTHPLACE (County & State, or foreign country) <u>ARLINGTON, VA</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>CHARLES CORBETT</u>						14. MOTHER'S MAIDEN NAME <u>MARY HOWARD</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>						16. SOCIAL SECURITY NO. <u>-</u>							
17. INFORMANT <u>PAUL WALTER</u>						Address <u>-</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY Congestion</u> 572.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>UREMIA</u> DUE TO (c) <u>DIVERTICULITIS</u>												INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>5 days</u> <u>8 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>8/23 1961</u> to <u>8/27 1961</u> , that (I) (we) last saw the deceased alive on <u>8/27 1961</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Robert G. Brewer</u> M.D.						22b. DATE SIGNED <u>8/27/61</u>							
22c. PHYSICIAN'S NAME (Type) <u>ROBERT G. BREWER</u>						22d. ADDRESS <u>8218 WISCONSIN AVE BETH MD.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>						23b. DATE THEREOF <u>8-30-1961</u>							
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>						23d. LOCATION (City, town or county) (State) <u>Suitland. Md.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Coulter's Sons</u>						25a. REGISTERAR'S SIGNATURE <u>Arthur S. Kraus</u>							
ADDRESS <u>Wash, D.C.</u>						25b. REGISTRAR'S SIGNATURE <u>DATE</u>							

08257

3887

(M)

(I)

24-1-72  
21-1-72  
8-1-72

24-1-72  
21-1-72  
8-1-72

24-1-72  
21-1-72  
8-1-72

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9268

## CERTIFICATE OF DEATH

09258

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>29 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>234 Eye Street, S.W.</b> d. STREET ADDRESS <b>234 Eye Street, S.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <b>Mildred Eugene Costanzo</b>			<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>1</b> Year <b>1961</b>		
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <b>August 7, 1927</b>		<b>9. AGE</b> (In years last birthday) <b>33 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months <b>33</b> Days <b>33</b> Hours <b>33</b> Min. <b>33</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Washington, D.C.</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>Robert Kittredge</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Mildred Mercer</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>579-30-5105</b>		<b>17. INFORMANT</b> <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Maryland</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral atelectasis, Respiratory failure &amp; right heart failure</b> DUE TO (b) <b>Pulmonary Hypertension</b> DUE TO (c) <b>Myxoma - left atrium</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 hours</b> <b>8 years</b> <b>8 years</b>					
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>					
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour <b>19</b> a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> <b>Washington, D.C.</b>		<b>(County)</b> <b>District of Columbia</b>		<b>(State)</b> <b>D.C.</b>	
<b>21. I certify that</b> <input checked="" type="checkbox"/> <b>(this hospital)</b> attended the deceased from <b>July 3, 1961</b> to <b>August 1, 1961</b> that <b>(he)</b> last saw the deceased alive on <b>August 1, 1961</b> , and that death occurred at <b>12:57 AM</b> , from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <b>W. Douglas Clark, M.D.</b>		<b>22b. ADDRESS</b> <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>		<b>22c. DATE SIGNED</b> <b>8/1/61</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>3 AUG. 1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>MT. OLIVET</b>	
<b>23d. LOCATION</b> (City, town or county) <b>WASHINGTON DC.</b>		<b>(State)</b> <b>D.C.</b>		<b>23e. REC'D BY REGISTRAR</b> <b>DATE AUG 3 '61</b>	
<b>23f. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Fries</b>		<b>23g. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Fries</b>			



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The Clinton Center, National  
Institutes of Health, Bethesda, Md.

W. Douglas Clark, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9269

## CERTIFICATE OF DEATH

Reg. Dist. No. 09259

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>DISTRICT OF</u> b. COUNTY <u>COLUMBIA.</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>1401 Tuckerman St NW</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Kenneth</u> Middle <u>Payne</u> Last <u>Craft.</u>				<b>4. DATE OF DEATH</b> Month <u>Aug.</u> Day <u>5</u> Year <u>1961</u>			
5. SEX <u>Male.</u>		6. COLOR OR RACE <u>Wh.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 6, 1898</u>	
9. AGE (In years past birthday) <u>62 yrs.</u>		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		9. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>				13. FATHER'S NAME <u>Heroy Craft.</u>			
14. MOTHER'S MAIDEN NAME <u>Cora Payne.</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>			
16. SOCIAL SECURITY NO. <u>578-07-6853</u>				17. INFORMANT <u>Mrs. Barbara Nicholas.</u> Address <u>938 Northampton Dr.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic carcinoma, left lung</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>metastases.</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Hour <u>—</u> o. m. <u>—</u> p. m. <u>—</u>		Month <u>—</u> Day <u>19</u> Year <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u>		(County) <u>—</u>		(State) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <u>July 17, 1961</u> , to <u>Aug 5, 1961</u> , that I last saw the deceased alive on <u>Aug 5, 1961</u> , and that death occurred at <u>10:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James L. Laubach</u> M.D.				ADDRESS (Street, city or town, state) <u>1806 FOX ST.</u>		DATE SIGNED <u>8/5/61.</u>	
PHYSICIAN'S NAME (Type) <u>James L. Laubach</u>				<u>Hyattsville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/8/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Maple Grove (Grove)</u>		22d. LOCATION (City, town, or county) (State) <u>Worcester, N. Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph F. Biechi Sons</u>				ADDRESS <u>Washington, D. C.</u>		24a. REC'D BY REGISTRAR <u>—</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>				DATE <u>AUG 8 '61</u>		<u>—</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9270											
CERTIFICATE OF DEATH											
Item 23 Film G294 9/6/61 mh											
09260											
1. PLACE OF DEATH a. COUNTY Montgomery						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Tennessee					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)						c. LENGTH OF STAY IN 1b 65 days					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital						d. STREET ADDRESS 1608 S. Lauderdale St.					
3. NAME OF DECEASED (Type or print) First Middle Last Laurie Renae Crawford						4. DATE OF DEATH Month Day Year August 28 19 61					
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-23-61		9. AGE (In years last birthday) yrs. 4 5		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ellie L. Crawford						14. MOTHER'S MAIDEN NAME Rita J. Yates					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes give war or data for service)		17. INFORMANT Hospital Records				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 344.1 DUE TO MENINGITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) INFECTED VENTRICULO ATRIAL SHUNT (c) HYDROCEPHALUS										INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 8 DAYS -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) LARYNGEAL MALACIA											
20c. TIME OF INJURY Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) June 24, 1961 to August 28, 1961		20g. (County) Memphis	
20h. (State) Tennessee				21. I certify that (H) (this hospital) attended the deceased from June 24, 1961 to August 28, 1961, that (H) (we) last saw the deceased alive on August 28, 1961, and that death occurred at 4:00 AM, from the causes and on the date stated above.							
22a. SIGNATURE R. W. Mackie						22b. DATE SIGNED August 28, 1961		22c. PHYSICIAN'S NAME (Type) R. W. MACKIE, CAPTAIN, MC, USN			
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.						22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shippment				23b. DATE THEREOF 30 August 1961		23c. NAME OF CEMETERY OR CREMATORY Unknown		23d. LOCATION (City, town or county) Memphis		23e. (State) Tennessee	
24. FUNERAL DIRECTOR'S SIGNATURE Frazier's Funeral Home, 389 Rhode Island Ave. N.W.						24a. REC'D BY REGISTRAR AUG 30 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

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CHARTERED BY THE BOARD OF DIRECTORS

*[Signature]*

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9271

## CERTIFICATE OF DEATH

09261

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>3 HRS. 20 MIN.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General Hospital</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LILLIAN SUE Crown</b>				4. DATE OF DEATH Month <b>August</b> Day <b>26</b> Year <b>1961</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <b>NE</b> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 26, 1961</b>		9. AGE (In years last birthday) yrs. <b>3</b>	IF UNDER 1 YEAR Months <b>3</b> Days <b>20</b>	IF UNDER 24 HRS. Hours <b>3</b> Min. <b>20</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>- -</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- -</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Crown</b>				14. MOTHER'S MAIDEN NAME <b>Lillian Virginia Crown Wood</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Hospital Records</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> <b>750X</b> DUE TO <b>Anencephalic.</b> Conditions, if any, which gave rise to immediate cause (b) <b>-</b> (c) <b>-</b> DUE TO <b>-</b> cause last. <b>-</b>						INTERVAL BETWEEN ONSET AND DEATH <b>-</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>-</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>-</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>-</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-</b>	20f. (City or town) <b>-</b>	(County) <b>-</b>	(State) <b>-</b>		
21. I certify that (I) (this hospital) attended the deceased from <b>8-26</b> , 19 <b>61</b> , to <b>8-26</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>8-26</b> , 19 <b>61</b> , and that death occurred at <b>5:15</b> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Lillian L. Leal</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/28/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. I. Leal, M. D.</b>				22d. ADDRESS <b>Gaithersburg, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>8-28-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>		23d. LOCATION (City, town or county) (State) <b>Gaithersburg - Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>		ADDRESS <b>Laytonsville - Md.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 1 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9272 CERTIFICATE OF DEATH

Reg. Dist. No. 09262

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>47X-3</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Marilea Nursing Home, 14,511 Colesville Road</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring Wash.</b> d. STREET ADDRESS <b>7444 Georgia Avenue, N.W. Apt. 201</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Thomas Herbert David</b>		4. DATE OF DEATH Month <b>August</b> Day <b>7</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 7, 1876</b>
9. AGE (In years last birthday) <b>85 yrs.</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>10</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Automobile Distributor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Clarion County, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Emil David</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Bishop</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Mr. Harold H. David</b> Address <b>Washington D.C.</b> <b>7452 Alaska Avenue, N.W.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>180X Congestive Heart Failure with</b> DUE TO <b>widespread metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>None</b> DUE TO (c) <b>None</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 28, 1961</b> to <b>Aug 7, 1961</b> that I last saw the deceased alive on <b>Aug 7, 1961</b> , and that death occurred at <b>8:20 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Silver Spring Md.</b> DATE SIGNED <b>Aug 9, 1961</b> ACTUAL SIGNATURE <b>John S. Rogers, M.D.</b> PHYSICIAN'S NAME (Type) <b>Silver Spring Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/11/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond H. Ziska</b> ADDRESS <b>Silver Spring, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 14 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Warner E. Pumphrey, Inc.</b> ADDRESS <b>8434 Georgia Avenue</b>		24c. REGISTRAR'S SIGNATURE <b>Warner E. Pumphrey</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

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9273  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09263

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Mont.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>53 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>50 Bethesda</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>				d. STREET ADDRESS <i>4507 Chase Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Lena</i> Middle <i>Elizabeth</i> Last <i>Jay</i>				4. DATE OF DEATH Month <i>Aug.</i> Day <i>20</i> Year <i>1961</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan 8, 1886</i>	
9. AGE (In years lost birthday) <i>75</i> yrs.		10. IF UNDER 1 YEAR Months <i>7</i> Days <i>12</i>		11. IF UNDER 24 HRS. Hours <i>12</i> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Frances Todd</i>				14. MOTHER'S MAIDEN NAME <i>Florence Floyd</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT <i>Dorothy Jay / Banker Above</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiovascular collapse</i> <i>332X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>cerebral thrombosis</i> DUE TO (c) <i>generalized arteriosclerosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>carcinoma of colon</i>						INTERVAL BETWEEN ONSET AND DEATH <i>6 weeks</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>April</i> 19 <i>61</i> to <i>Aug 20</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>August 20</i> 19 <i>61</i> and that death occurred at <i>12</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>Willard R. Ehrmantraut M.D.</i>				22b. ADDRESS <i>4890 Battery Lane, Bethesda, Md.</i>		22c. DATE SIGNED <i>8/20/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>Willard R. Ehrmantraut</i>		22d. ADDRESS <i>4890 Battery Lane, Bethesda, Md.</i>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8/23/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Rockville, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>				ADDRESS <i>Bethesda, Maryland</i>		25a. REC'D BY REGISTRAR <i>AUG 24 '61</i>	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

8333

EXHIBIT OF DEEDS

8333

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9274  
CERTIFICATE OF DEATH  
09264

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 7 days		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Virginia		b. COUNTY Winchester	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) First Middle Last Leman Elroi Dehart		4. DATE OF DEATH Month Day Year August 12 19 61		5. SEX Male	
6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-10-88		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James C. Dehart	
14. MOTHER'S MAIDEN NAME Rebecca Jane Heckman		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II		17. INFORMANT Bertha S. Dehart		Address Same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma pancreas - metastatic</u> DUE TO (b) <u>Carcinoma pancreas</u> DUE TO (c) <u>157X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 6 mo.		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Arlington		(County) Va.		(State)	
21. I certify that (X) (this hospital) attended the deceased from August 5, 1961, to August 12, 1961, that (X) (we) last saw the deceased alive on August 12, 1961, and that death occurred at 9:10 PM, from the causes and on the date stated above.		22a. SIGNATURE Bruce Harold Rice M.D.		22b. DATE August 14, 1961		22c. PHYSICIAN'S NAME (Type) BRUCE HAROLD RICE, LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF August 16, 1961		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) Arlington		(State) Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		ADDRESS Baltimore, Md.		25a. REC'D BY REGISTRAR AUG 16 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Harris		DATE	

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Virginia  
Winchester

U. S. Naval Hospital

3130 Valley Ave.

U. S. Naval Hospital

James

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James

10-10-88

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Pennsylvania

U. S. Navy

Officer

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August 2

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August 12, 1901

U. S. Naval Hospital, Winchester, Va.

Winchester

U. S. Naval Hospital

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August 12, 1901

U. S. Naval Hospital, Winchester, Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9275

## CERTIFICATE OF DEATH

09265

<b>1. PLACE OF DEATH</b> a. COUNTY Montgomery			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia b. COUNTY ✓		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington		
c. LENGTH OF STAY IN 1b 2 Mo. - 6 Days			d. STREET ADDRESS 1754 Massachusetts Avenue		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last Jacobus DIJKMAN			<b>4. DATE OF DEATH</b> Month Day Year August 18 1961		
<b>5. SEX</b> Male		<b>6. COLOR OR RACE</b> Caucasian		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
<b>8. DATE OF BIRTH</b> February 22, 1900		<b>9. AGE</b> (In years last birthday) 61 yrs.		<b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Warehouseman		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> Storage		<b>11. BIRTHPLACE</b> (County & State, or foreign country) HOLLAND	
<b>12. CITIZEN OF WHAT COUNTRY?</b> HOLLAND					
<b>13. FATHER'S NAME</b> Unknown			<b>14. MOTHER'S MAIDEN NAME</b> Unknown		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) NO		<b>16. SOCIAL SECURITY NO.</b> Unknown		<b>17. INFORMANT</b> (Son) Robert O. DIJKMAN Address 1754 Mass. Ave., Washington, D.C.	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Transitional Cell Carcinoma of the bladder, with metastasis</i> Conditions, if any, which gave rise to immediate cause (b) <i>199X</i> (c) <i>1 year</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. 19		<b>20d. INJURY OCCURRED</b> While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that</b> (this hospital) attended the deceased from 12 June 1961 to 18 August 1961, that (I) (we) last saw the deceased alive on 18 August 1961, and that death occurred at 4:05 PM from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <i>L. N. Cahill</i>		<b>22b. DATE</b> 20 August 1961		<b>22c. PHYSICIAN'S NAME</b> (Type) L. N. CAHILL, LCDR MC USN	
<b>22d. ADDRESS</b> U. S. Naval Hospital, NNM, Bethesda, Md.					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) Burial		<b>23b. DATE THEREOF</b> 22 Aug 1961		<b>23c. NAME OF CEMETERY OR CREMATORY</b> Sherwood Cemetery	
<b>23d. LOCATION</b> (City, town or county) Talbot County,		<b>23e. (State)</b> Maryland			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> Robert A. Pumphrey		<b>24a. ADDRESS</b> 7557 Wisconsin Ave. Bethesda, Md.		<b>25a. REC'D BY REGISTRAR</b> AUG 23 '61	
<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur L. Haines</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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9276

CERTIFICATE OF DEATH

9266

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		d. STREET ADDRESS <b>REF #1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>Brooke</b> Last <b>Dinwiddie</b>				4. DATE OF DEATH Month <b>August</b> Day <b>26</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 30, 1886</b>	
9. AGE (In years last birthday) <b>75</b> Yrs.		IF UNDER 1 YEAR Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min.		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse, retired Nursing</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>			
13. FATHER'S NAME <b>Alban Brooke</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Elizabeth Pleasants</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>218-34-7450</b>		17. INFORMANT <b>Hospital records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO (b) <b>Coronary arteriosclerosis (marked)</b> DUE TO (c) <b>Cardiomegaly</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cirrhosis of the liver</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>December 8, 1960</b> to <b>8/26/61</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>8/26/61</b> , and that death occurred at <b>12:15 p.m.</b> from the causes and on the date stated above.				22a. SIGNATURE <b>J. P. Martin, M.D.</b>			
22c. PHYSICIAN'S NAME (Type) <b>J. P. Martin, M.D.</b>				22d. ADDRESS <b>Medical Center, Sandy Spring, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 29, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Friends' Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Sandy Spring, Montg., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC., SILVER SPRING, MD.</b> <b>Raymond A. Ziska</b>				25a. REC'D BY REGISTRAR <b>AUG 30 '61</b>		25b. REGISTRAR'S SIGNATURE <b>John S. Harris</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**9277** **CERTIFICATE OF DEATH** **09267**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Chevy Chase</u> d. STREET ADDRESS <u>31 Oxford St.,</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>John V. Dolan</u>		<b>4. DATE OF DEATH</b> <u>Aug. 16 1961</u>		<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>5/29/03</u>		<b>9. AGE</b> (In years last birthday) <u>58</u> yrs. IF UNDER 1 YEAR: Months <u>16</u> Days <u>19</u> Hours <u>61</u> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Physician</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Gaylordville, Conn.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				<b>13. FATHER'S NAME</b> <u>Albert Dolan</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Alice Roach</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>None</u>				<b>17. INFORMANT</b> <u>wife, Philomena Dolan</u> Address <u>same as above</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse, postoperative</u> DUE TO (b) <u>Bronchogenic Carcinoma with extensive metastasis, unresectable</u> DUE TO (c) <u>162.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>6 months +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>May 1961</u> <b>to</b> <u>Aug 16, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Aug 16, 1961</u> , <b>and that death occurred at</b> <u>10:12</u> <b>M.</b> <b>from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <u>J. D. Peabody Jr.</u> M.D.						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>Aug 16, 1961</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>J. D. Peabody Jr.</u>		<b>22d. ADDRESS</b> <u>1150 Conn. Ave. Wash. D.C.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>8/19/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Ft. Lincoln Cemetery</u>				<b>23d. LOCATION</b> (City, town or county) <u>Prince George Co. Md.</u> (State)			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey</u>						<b>ADDRESS</b> <u>Bethesda, Maryland</u>		<b>25a. REC'D BY REGISTRAR</b> <u>AUG 21 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician and completely filled out by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02881

02881

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Robert A. Broughton, Bethesda, Maryland

May 21, 61

July 1, 1961

1400 Town Ave.

Ann D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

9278

09269

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Sanitarium</b>			d. STREET ADDRESS <b>2901 Conn. Avenue, N. W</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Kathryn</b> Middle <b>E</b> Last <b>Dunkhorst</b>			4. DATE OF DEATH Month <b>August</b> Day <b>14</b> Year <b>19 61</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/2/1877</b>		9. AGE (In years lost birthday) <b>83</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>William H. Dunkhorst</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Fuss</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Dowell-Granddaughter-same 2d</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bowel Obstruction</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA of Rectum</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>Feb 28 1949</b> to <b>Aug 14 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 13 1961</b> , and that death occurred at <b>4:30</b> M, from the causes and on the date stated above. 22a. SIGNATURE <b>Horace H. Custis, Jr.</b> 22c. PHYSICIAN'S NAME (Type) <b>Horace H. Custis, Jr.</b> 22d. ADDRESS <b>1832 1852 Columbia Road NW, Wash. D.C</b> 22b. DATE SIGNED <b>8-14-61</b>					INTERVAL BETWEEN ONSET AND DEATH <b>70 days</b> <b>2 YRS</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/17/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cem.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>AUG 18 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9279 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09270

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>37 minutes</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium &amp; Hosp.</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges Co.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>5601 Chillum Hgts Dr.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Bernard Lewis Edwards Jr.</b>				4. DATE OF DEATH Month Day Year <b>8 31 1961</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-30-18</b>	
9. AGE (In years last birthday) <b>43</b> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Crane Operator D.C. Government</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>			
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>			
13. FATHER'S NAME <b>Bernard L. Edward Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth ?</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or date of service) <b>yes. W.W.II</b>				16. SOCIAL SECURITY NO. <b>W.W.II</b>			
17. INFORMANT <b>Ruby Sweatman-Sister in law</b>				Address <b>Same Address-</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 420. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.</b> INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschart</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>8-31-61</b>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/5/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or country) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR <b>Kalley's Funeral Home, Inc.</b>				24a. REC'D BY REGISTRAR <b>SEP 7 '61</b>		24b. REGISTRAR'S SIGNATURE <b>O. L. L. L.</b>	

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Place of birth: [illegible]  
6. Usual residence: [illegible]  
7. Cause of death: [illegible]  
8. Date of death: [illegible]  
9. Time of death: [illegible]  
10. Signature of medical examiner: [illegible]  
11. Signature of coroner: [illegible]  
12. Signature of registrar: [illegible]

9280

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

09271

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>90 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Summit</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>67 X-3</b> d. STREET ADDRESS <b>27 Sheffield Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Roy</b> Middle <b>Reed</b> Last <b>Edwards</b>		4. DATE OF DEATH Month <b>August</b> Day <b>22</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 10, 1927</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contracting Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	9. AGE (In years last birthday) <b>34</b> IF UNDER 1 YEAR: Months <b>34</b> Days <b>34</b> Hours <b>34</b> Min. <b>34</b>
11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Victor Edwards</b>		14. MOTHER'S MAIDEN NAME <b>Lena Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>WWII</b>		16. SOCIAL SECURITY NO. <b>423-26-4747</b>	
17. INFORMATION The Medical Record Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myelogenous Leukemia with acute blastic crisis</b> DUE TO <b>crisis</b> 204.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 24</b> , 19 <b>61</b> , to <b>August 22</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>August 22</b> , 19 <b>61</b> , and that death occurred at <b>12:49 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b> DATE SIGNED <b>August 28 1961</b>			
ACTUAL SIGNATURE <b>Geo. H. Porter</b>		M.D. <b>THE CLINICAL CENTER, NATIONAL INSTITUTES OF HEALTH, BETHESDA 14, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>GEORGE H. PORTER, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit 8/23/61</b>	22b. DATE THEREOF <b>8/23/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Forest Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Birmingham, Alabama</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>Bethesda, Maryland</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur J. Frank</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2280

REGISTRATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9281

09272

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>16 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Union</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>2051 Pleasant Parkway</b> d. STREET ADDRESS <b>67X-3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Paul Robert Eskin</b>		4. DATE OF DEATH Month <b>August</b> Day <b>13</b> Year <b>19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 25, 1941</b>	9. AGE (In years last birthday) <b>19</b> yrs.	IF UNDER 1 YEAR Months <b>21</b> Days <b>13</b> Hours <b>13</b> Min. <b>13</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New Jersey</b>	
13. FATHER'S NAME <b>Benjamin Eskin</b>		14. MOTHER'S MAIDEN NAME <b>Helen Eroncrantz</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1959 - 1960 138-32-7299</b>		17. INFORMANT <b>The Medical Record</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myelogenous Leukemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Congestive Heart Failure</b> DUE TO (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <b>21 months</b> <b>2 days</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 28, 1961</b> to <b>August 13, 1961</b> , that (I) (we) last saw the deceased alive on <b>August 13, 1961</b> , and that death occurred at <b>10:20 p.m.</b> from <b>causes</b> and on the date stated above.					
22a. SIGNATURE <b>Geo. H. Porter, III, M.D.</b>		22b. DATE <b>8/14/61</b>		22c. PHYSICIAN'S NAME (Type) <b>GEO. H. PORTER, III, M.D.</b>	
22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Trans 8/14/61</b>		23b. DATE THEREOF <b>8/14/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hebrew Cemetery</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>AUG 16 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kinne</b>	

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2021 Pleasant way

The Clinical Center, Bethesda, Md.

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Low Jersey

Low Jersey

Low Jersey

Johnston

Johnston

1938-1939 The Clinical Center, Bethesda, Md.

1938 - 1939

1938

Chronic Polyarthritis

22

Consecutive Heart Failure

2 days

22

July 22, 1941

10:30 p.m.

August 13, 1941

22

X

The Clinical Center, Bethesda, Md.

DR. H. H. H. H. H.

Low Jersey

Low Jersey

Low Jersey

Class 2

Class 2

Class 2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>Flushing</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>						c. LENGTH OF STAY IN 1b <b>60 days</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>						d. STREET ADDRESS <b>141-49 70th Road, Kew Garden Hills</b>					
3. NAME OF DECEASED (Type or print) <b>Benjamin Harold Ezrin</b>						4. DATE OF DEATH Month <b>August</b> Day <b>12</b> Year <b>1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>July 28, 1896</b>		9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store Owner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Business</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Russia</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>											
13. FATHER'S NAME <b>Max Ezrin</b>						14. MOTHER'S MAIDEN NAME <b>Anna Zirlin</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW I</b>						16. SOCIAL SECURITY NO. <b>051-14-1610</b>					
17. INFORMANT <b>The Medical Record</b>						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Cardiac Arrhythmia &amp; Acute Renal Shutdown</b> DUE TO (b) <b>Carcinoid Heart Disease</b> DUE TO (c) <b>Malignant Carcinoid with Hepatic &amp; Peritoneal Metastasis</b>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerosis &amp; Arteriosclerotic Heart Disease</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>June 13, 1961</b>		20g. (County) <b>August 12, 1961</b>	
21. I certify that <b>he</b> (this hospital) attended the deceased from <b>June 13, 1961</b> to <b>August 12, 1961</b> , that <b>he</b> (we) last saw the deceased alive on <b>August 12, 1961</b> , and that death occurred at <b>1:10 PM</b> , from the causes and on the date stated above.											
22e. SIGNATURE <b>O. Wesley McBride</b>						22b. DATE SIGNED <b>8/12/61</b>					
22c. PHYSICIAN'S NAME (Type) <b>O. Wesley McBride, M.D.</b>						22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>8/15/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Park</b>		23d. LOCATION (City, town or county) <b>Paramus, New Jersey</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>						ADDRESS <b>Bethesda, Md.</b>		25a. REG. BY REGISTRAR <b>Aug 16 61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

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The Clinical Center, Bethesda, Md.

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July 28, 1962

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John Warner

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Anna Karin

The Clinical Center

111-111 John Road, Los Gatos, Calif.

W. I.

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Technical Center, University of California, Los Angeles

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Caroline Mary Dixon

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Biologic & Chemical Laboratory

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Hydroxylation & Acetylation of Benzene

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The Clinical Center, University of California, Los Angeles

O. Wesley McBride, M.D.

Genet. Lab.

8/12/61

111-111 John Road, Los Gatos, Calif.

11 11 1962

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Bethesda, Md.

Robert A. Emery

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

09274

9283

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>47X3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN lb <u>32 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens SAN.</u>				d. STREET ADDRESS <u>1500-MASS. AVE. N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARGARET A.</u> Middle <u>Feldt</u> Last <u></u>				4. DATE OF DEATH Month <u>8</u> Day <u>28</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/1/90</u>		9. AGE (In years lost birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse and Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>BUFFALO, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>MR. NAT. C. KODGON</u> Address <u>7501 HOLIDAY TERRACE, BETHESDA, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Renal Failure Heart Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Post Prosthesis Right Hip (Subcapital Fracture)</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fracture of hip from fall Wash DC</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>April 21 1961</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Wash DC</u> (County) <u></u> (State) <u></u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> to <u>Aug 28 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug 28 1961</u> , and that death occurred at <u>12 P.</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u></u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr I. S. GRISOFF</u>				22d. ADDRESS <u>4500 Conn Ave</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation 8/31/61</u>		23b. DATE THEREOF <u>8/31/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>Prince Georges, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>				ADDRESS <u>2901 14th St. N.W.</u>		25a. REC'D BY REGISTRAR <u>AUG 30 61</u>	
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15334

15333



*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "Washington" and "Department" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9284

CERTIFICATE OF DEATH

09275

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY in 1b <u>2 1/2 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>10808 BREEWOOD RD.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>110808 BREEWOOD RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>FRANK — FERRARA</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>AUGUST 10 1961</u>									
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>APRIL 22, 1976</u>		<b>9. AGE</b> (In years last birthday) <u>25</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>RETIRED LABORER</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>—</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>ITALY</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>1st PAPERS, USA.</u>	
<b>13. FATHER'S NAME</b> <u>GIUSEPPE FERRARA</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>NOT KNOWN.</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>NO</u>		<b>17. INFORMANT</b> <u>ALEX FERRARA</u>				<b>Address</b> <u>10808 BREEWOOD RD.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 4-2-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE - 2+ yrs</u> (a), stating the underlying cause last. DUE TO (c) <u>—</u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>5 DAYS</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <u>"PLEURISY" - 5 WEEKS PREVIOUSLY</u>										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>—</u>		<b>20f. (City or town)</b> <u>—</u> <b>(County)</b> <u>—</u> <b>(State)</b> <u>—</u>					
<b>21. I certify that (I) (this hospital)</b> attended the deceased from <u>AUG. 10, 1961</u> to <u>AUG. 10, 1961</u> , that (I) (we) last saw the deceased alive on <u>AUG. 10, 1961</u> , and that death occurred at <u>5:15 PM</u> from the causes and on the date stated above.													
<b>22a. SIGNATURE</b> <u>Gene U. Cohen M.D.</u>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <u>AUG. 10, 1961</u>				<b>22b. DATE SIGNED</b>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>GENE U. COHEN, M.D.</u>						<b>22d. ADDRESS</b> <u>931 PERSHING DR., SILVER SPRING</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>8/14/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Gate of Heaven Cemetery</u>				<b>23d. LOCATION</b> (City, town or county) <u>Montgomery County, Maryland</u> (State) <u>MD</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Raymond E. Pumphrey, Inc.</u>						<b>25a. REC'D BY REGISTRAR</b> <u>AUG 16 '61</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kneass</u>			

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Washington, D.C.  
1944  
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Printed in the United States of America



9285

## CERTIFICATE OF DEATH

Reg. Dist. No.

09276

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Resmor Sanitarium</b>				d. STREET ADDRESS <b>5915 Sonoma Road</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Arthur W. FERRIN</b>				4. DATE OF DEATH Month Day Year <b>8 10 1961</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/8/63</b>	9. AGE (In years lost birthday) <b>98</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <b>3 0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>New Hampshire</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME (Unknown) <b>Ferrin</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-18-8580</b>		17. INFORMANT Address <b>John A. Carlson-Friend-same 2d</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>NATURAL CAUSES</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CORONARY OCCLUSION</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/8</b> , 19 <b>61</b> , to <b>8/10</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>8/9</b> , 19 <b>61</b> , and that death occurred at <b>2:45 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>I. L. Marks</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>6306 Woodson Ave 8/10/61</b>			
PHYSICIAN'S NAME (Type) <b>I. L. MARKS</b>				<b>Chery Chase 15, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>8/16/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>AUG 18 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





(M)

0288

Postmaster

Bethesda

7500 Arden Lane

Box 2

Private

Housewife

Joseph H. Howard

(I)

Name

John D. Lee, none-in-law since 24

Adelaide Kennedy

July 1, 1987

Providence, Rhode Island

August 28

Bethesda

Postmaster

0037

Post Office

John Howard - Providence, Rhode Island

June 2 1987

John B. Marshall

X

Robert A. Murphy, Bethesda, Maryland  
Street-Transit 1/30/01 Swan Point Cemetery  
Providence, Rhode Island

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

168  
9287  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09278

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>W. Hyattsville</i>					
c. LENGTH OF STAY in 1b <i>24 days</i>				d. STREET ADDRESS <i>3202 Kimberly Rd.</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington Sanitarium + Hosp</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Dorothy Elizabeth Fones</i>		First Middle Last		4. DATE OF DEATH Month <i>8</i> Day <i>15</i> Year <i>1961</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11-3-24</i>			
9. AGE (In years last birthday) <i>36 yrs.</i>		IF UNDER 1 YEAR Months <i>8</i> Days <i>15</i>		IF UNDER 24 HRS. Hours <i>15</i> Min. <i>1</i>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary + Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>J. H. Malseed</i>				14. MOTHER'S MAIDEN NAME <i>Alice Borum</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>None</i>				16. SOCIAL SECURITY NO. <i>574-26-4217</i>					
17. INFORMANT <i>and old Hosp. records.</i>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Atelectasis + Insufficiency - Severe</i> DUE TO (b) <i>Bilateral Hydrothorax + Ascites</i> DUE TO (c) <i>Carcinoma Breast right &amp; generalized Carcinomatosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>170X</i>								INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs.</i> <i>7 days</i> <i>about 6 mos.</i>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Apr. 7</i> , 19 <i>61</i> , to <i>8-15</i> , 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>8-15</i> , 19 <i>61</i> , and that death occurred at <i>9:45</i> A.M. from the causes and on the date stated above.									
22a. SIGNATURE <i>Read N. Calvert, M.D.</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <i>Read N. Calvert, M.D.</i>				22d. ADDRESS <i>909 Pershing Drive, Silver Spring, Md.</i>					
23a. BURIAL, CREMATION, OR REMOVAL (Specify)		23b. DATE THEREOF <i>8/18/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Arlington, Virginia</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Pumphrey, Inc.</i>				ADDRESS <i>8434 Georgia Avenue</i>		25a. RECEIVED BY REGISTRAR <i>AUG 21 61</i>			
25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>				DATE					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9288

## CERTIFICATE OF DEATH

09279

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>36 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>5367 Blaine Street, N. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Benjamin Jerome Fonville</b>		<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>25</b> Year <b>1961</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>11-4-13</b>
<b>9. AGE</b> (In years last birthday) <b>47 yrs.</b>		<b>10. IF UNDER 1 YEAR</b> Months <b>4</b> Days <b>7</b>	<b>11. IF UNDER 24 HRS.</b> Hours <b>12</b> Min. <b>00</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Analytic statistician</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>U. S. Government</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>North Carolina</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Benjamin S. Fonville</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Lillian Holden</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <b>WW II</b>		<b>16. SOCIAL SECURITY NO.</b> <b>(W) Mrs. Olga V. Fonville same as #2 above</b>	
<b>17. INFORMANT</b> <b>(W) Mrs. Olga V. Fonville same as #2 above</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hodgkins Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) <b>pneumonia</b>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20. INTERVAL BETWEEN ONSET AND DEATH</b> <b>4 yrs.</b>	
<b>21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>pneumonia</b>		<b>22. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>23a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>		<b>24. TIME OF INJURY</b> Month, Day, Year Hour <b>19</b> o.m. <b>12:00</b> p.m.	
<b>25. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>26. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>(City or town)</b> <b>(County)</b> <b>(State)</b>	
<b>27. I certify that</b> (this hospital) attended the deceased from <b>July 20</b> , 19 <b>61</b> to <b>August 25</b> , 19 <b>61</b> , that (we) last saw the deceased alive on <b>August 25</b> , 19 <b>61</b> , and that death occurred <b>12:00 PM</b> , from the causes and on the date stated above.		<b>28. SIGNATURE</b> <b>John W. Brackett, Jr.</b> M.D. <b>29. PHYSICIAN'S NAME</b> (Type) <b>JOHN W. BRACKETT, JR. LT MC USN</b>	
<b>30. ATTENDING PHYS.</b> <input type="checkbox"/> <b>31. MED. DIRECTOR</b> <input type="checkbox"/> <b>32. STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>33. DATE</b> <b>August 25, 1961</b>	
<b>34. ADDRESS</b> <b>U. S. Naval Hospital, Bethesda, Md.</b>		<b>35. REC'D BY REGISTRAR</b> <b>AUG 29 '61</b>	
<b>36. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hume</b>		<b>37. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	
<b>38. DATE THEREOF</b> <b>August 29, 1961</b>		<b>39. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b>	
<b>40. LOCATION</b> (City, town or county) <b>Arlington</b>		<b>41. (State)</b> <b>Va.</b>	
<b>42. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Stewart Funeral Home, 30 H St. N.E., Washington, D.C.</b>		<b>43. ADDRESS</b> <b>Stewart Funeral Home, 30 H St. N.E., Washington, D.C.</b>	
<b>44. REC'D BY REGISTRAR</b> <b>AUG 29 '61</b>		<b>45. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hume</b>	

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HOOPER'S DISC

DISC

John W. Hooper

John W. Hooper, D.D., Secretary of the U.S. National Academy of Sciences

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9289

## CERTIFICATE OF DEATH

09280

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ednor</b>				c. LENGTH OF STAY IN 1b <b>Two months</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Belmont Nursing Home</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>			
3. NAME OF DECEASED (Type or print) <b>Mary Elizabeth Foright</b>				d. STREET ADDRESS <b>7001 - 31st Street N.W.</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 22, 1876</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Hopkinsville, Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Edmonson</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Thacker</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Mrs. Evelyn M. Shah</b>				Address <b>7001 - 31st Street N.W. Washington D.C.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recurrent (post operative) left breast carcinoma</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture right hip (6/6) with open reduction</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>uncomplicated</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/19</b> , 19 <b>61</b> to <b>8/21</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>8/5</b> , 19 <b>61</b> , and that death occurred at <b>4</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>John P. Martin MD.</b>				22b. ADDRESS <b>Sandyspring, Maryland</b>		22c. DATE SIGNED <b>8/21/61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/23/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Prince George's County, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b> <b>Warner E. Pumphrey, Inc.</b>				25a. REC'D BY REGISTRAR <b>AUG 25 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur E. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Coroner Notified and approved

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02980



*[Faint, mostly illegible text covering the page, possibly bleed-through from the reverse side. Some words like "Washington, D.C." and "1941" are visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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9290  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
09281

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>				e. STREET ADDRESS <u>7906 Woodbury Drive</u>			
3. NAME OF DECEASED (Type or print) <u>Raymond Clifton Freas, Sr.</u>				4. DATE OF DEATH <u>August 8, 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-7-98</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>self employed</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co. Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Samuel Allen Freas</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Hayes</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-03-8610</u>			
17. INFORMANT <u>Mr. Raymond C. Freas, Jr.</u>				Address <u>2936 Marlow Road Silver Spring, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>332X</u> DUE TO <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>arterio-sclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/5</u> , 19 <u>61</u> , to <u>8/8</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8/8</u> , 19 <u>61</u> , and that death occurred at <u>2:38</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>A. B. Little</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>A. B. LITTLE</u>				22d. ADDRESS <u>6911 5th St. N.W. Wash. 12, D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/11/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u>				ADDRESS <u>8434 Georgia Avenue Silver Spring, Maryland</u>		25a. REC'D BY REGISTRAR <u>AUG 11 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

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Montgomery

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Reynolds Clifton Forest St

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9291

09282

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>719 Monroe St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>GARGES</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>August 10 1961</b>													
<b>5. SEX</b> <b>Unknown</b>		<b>6. COLOR OR RACE</b> <b>Caucasian</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>8-8-61</b>		<b>9. AGE</b> (in years last birthday) yrs. <b>2</b> IF UNDER 1 YEAR Months Days Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Infant</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Bethesda, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Daniel Tyler Garges</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Margaret Ann Duncan</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> <b>16. SOCIAL SECURITY NO.</b> <b>(F) Daniel T. Garges same as #2 above</b> <b>17. INFORMANT</b> Address									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MULTIPLE CONGENITAL ANOMALIES</b> 759.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)									
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 8, 1961</b> to <b>August 10, 1961</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>August 10, 1961</b> , and that death occurred at <b>7:22 AM</b> , from the causes and on the date stated above.																	
<b>22a. SIGNATURE</b> <b>James J. Ryskamp, Jr.</b> M.D.				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>				<b>22b. DATE SIGNED</b> <b>August 10, 1961</b>									
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>JAMES J. RYSKAMP, JR. LT MC USN</b>				<b>22d. ADDRESS</b> <b>U. S. Naval Hospital, Bethesda, Md.</b>													
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>August 15, 1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b>				<b>23d. LOCATION</b> (City, town or county) (State) <b>Arlington Va</b>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Tyson Wheeler</b>				<b>ADDRESS</b> <b>Rockville</b>				<b>25a. REC'D BY REGISTRAR</b> <b>AUG 11 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Conrad S. Kras</b>							

2051231 XV3

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

00288

00287

(M)

(C)

(I)

U. S. Naval Hospital, Bethesda, Md.  
August 1, 1941  
Colonel  
The Surgeon General  
Washington, D. C.  
Dear Sir:  
Enclosed for you are 4 copies  
of the report of the  
investigation of the  
accident which occurred  
on the night of July 31,  
1941, at the U. S. Naval  
Hospital, Bethesda, Md.,  
when a patient died as a  
result of a fall from the  
bed.

Very respectfully,  
J. H. E. GUNTER, JR., M.D.

*John H. E. Gunter, Jr.*

John H. E. Gunter, Jr., M.D.

August 1, 1941

Rockville, Md.

Typed Name, Rockville, Md.

Washington

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9292

## CERTIFICATE OF DEATH

09283

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>4 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Scranton</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Scranton</b> d. STREET ADDRESS <b>415 Arthur Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>John Francis Gibbons</b>		4. DATE OF DEATH Month <b>August</b> Day <b>7</b> Year <b>1961</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 26, 1905</b>		9. AGE (In years last birthday) <b>55 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Accounting</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John Gibbons</b>								14. MOTHER'S MAIDEN NAME <b>Anna McGuire</b>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unascertainable</b>				17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Maryland</b>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable Septicemia with hypotension</b> 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Renal Failure</b> DUE TO (c) <b>Acute leukemia</b> INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>7 days</b> <b>6 months</b>																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that <del>at</del> (this hospital) attended the deceased from <b>August 3, 1961</b> to <b>August 7, 1961</b> , that <del>we</del> (we) last saw the deceased alive on <b>August 7, 1961</b> , and that death occurred at <b>5:20 PM</b> from the causes and on the date stated above.																			
22a. SIGNATURE <b>Robert H. Levin M.D.</b>								ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>8/7/61</b>				22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) <b>Robert H. Levin, M.D.</b>								22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit 8-8-61</b>				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cemetery Scranton, Penna.</b>				23d. LOCATION (City, town or county) (State)							
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>								ADDRESS <b>Bethesda, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 10 '61</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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John Gibbons

John Gibbons

1 day

1 day

1 day

1000 North Avenue

The Clinical Center, Bethesda, Md.

1

August 25

Gibbons

John

John

August 25, 1955

John

John

1

John Gibbons

John Gibbons

John Gibbons

1

John Gibbons

1000 North Avenue, Bethesda, Md.

1

1 day

1000 North Avenue, Bethesda, Md.

1 day

1000 North Avenue, Bethesda, Md.

1 day

1000 North Avenue, Bethesda, Md.

1

August 25, 1955

August 25, 1955

August 25, 1955

August 25, 1955

The Clinical Center, Bethesda, Md.

Robert H. Levin, M.D.

August 25, 1955

August 25, 1955

August 25, 1955

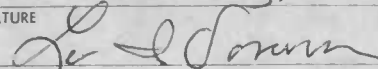
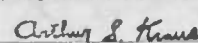
August 25, 1955

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

9293

09284

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> c. LENGTH OF STAY IN lb <b>8018 Glendale Rd.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8018 Glendale Rd.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>51 Chevy Chase</b> d. STREET ADDRESS <b>8018 Glendale Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) <b>LORETTO S. GIBNEY</b>		<b>4. DATE OF DEATH</b> Month <b>Aug.</b> Day <b>30,</b> Year <b>19 61</b>		<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Nov. 22, 1888</b>		<b>9. AGE</b> (In years last birthday) <b>72</b> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months <b>9</b> Days <b>8</b></td> <td>Hours <b></b> Min. <b></b></td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months <b>9</b> Days <b>8</b>	Hours <b></b> Min. <b></b>
IF UNDER 1 YEAR	IF UNDER 24 HRS.																
Months <b>9</b> Days <b>8</b>	Hours <b></b> Min. <b></b>																
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>-----</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Illinois</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>					
<b>13. FATHER'S NAME</b> <b>Mark L. Salamon=</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Leddy</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service) <b>16. SOCIAL SECURITY NO.</b> <b>None</b>				<b>17. INFORMANT</b> <b>Lorraine G. Swagart-daughter-same 2d</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>INVALID &amp; MULTIPLE SCLEROSIS 18 YRS</b>												INTERVAL BETWEEN ONSET AND DEATH <b>10 MINUTE</b> <b>10 YRS</b>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>							
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>Aug 8, 1961</b> to <b>Aug 30, 1961</b> ; that (I) (we) last saw the deceased alive on <b>Aug 27, 1961</b> , and that death occurred at <b>6:55 AM</b> , from the causes and on the date stated above.																	
<b>22a. SIGNATURE</b> 				<b>22b. DATE</b> <b>8-30-61</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>LEO I. DONOVAN</b>		<b>22d. ADDRESS</b> <b>8218 Wisconsin Ave., Bethesda, Md.</b>		<b>22e. DATE SIGNED</b> <b>8-30-61</b>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>9/2/61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Agnes Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) <b>West Chester, Penna.</b>		<b>(State)</b>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert A. Pumphrey</b>				<b>25a. REC'D BY REGISTRAR</b> <b>BEP 5 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> 		<b>25c. DATE</b>		<b>25d. ADDRESS</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

02280

02280

(M)

(7)

Myland

Chew Chase

Bois d'Ardenne Road

Nov. 22, 1888

Illinois

Genevieve

Mrs. J. Salmon

Myland

Forrest G. Salmon - son of

John

Butler, 9/26/89, St. Agnes Cemetery, West Chester, Penna.

Robert A. Murphy, Bethesda, Maryland, 8/8/89, Cal. 1 Km.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9294

CERTIFICATE OF DEATH

09285

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY in 1b <b>4 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution; Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>Binghamton</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Binghamton</b> d. STREET ADDRESS <b>27 Leroy Street</b>		
<b>3. NAME OF DECEASED</b> (Type or print) <b>Leo Edward Gilroy</b>			<b>4. DATE OF DEATH</b> Month <b>August 10,</b> Day <b>19</b> Year <b>61</b>		
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	
<b>8a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Optician</b>		<b>8b. KIND OF BUSINESS OR INDUSTRY</b> <b>Office</b>		<b>9. AGE</b> (In years last birthday) <b>50</b> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Optician</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Office</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>New York</b>	
<b>13. FATHER'S NAME</b> <b>Frank P. Gilroy</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Eva P. Cole</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>070-03-5348</b>		<b>17. INFORMANT</b> <b>The Medical Records</b> <b>The Clinical Center, Bethesda 14, Maryland</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left Ventricular Failure</b> DUE TO (b) <b>Acquired Aortic Stenosis</b> DUE TO (c) <b>6 months</b>			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 hours</b>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner)			<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)		
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from August 6, 1961, to August 10, 1961, that (I) (we) last saw the deceased alive on August 10, 1961, and that death occurred at 6:15 p.m. from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <b>RICHARD P. ANDERSON, M.D.</b>			<b>22b. DATE SIGNED</b> <b>8/11/61</b>		
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>RICHARD P. ANDERSON, M.D.</b>			<b>22d. ADDRESS</b> <b>The Clinical Center National Institutes Of Health, Bethesda 14, Maryland</b>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial-transit 8-11-61</b>		<b>23b. DATE THEREOF</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Chenango Valley Cem.</b>	
<b>23d. LOCATION</b> (City, town or county) <b>Broome County, New York</b>		<b>(State)</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>ROBERT A. PUMPHREY</b>			<b>ADDRESS</b> <b>Bethesda, Md.</b>		
<b>25a. REC'D BY REGISTRAR</b> <b>AUG 16 '61</b>			<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Hume</b>		

00288

00288



NEW YORK

STANLEY

1935

STANLEY

STANLEY

The Clinical Center, Washington, D.C.

STANLEY

STANLEY

STANLEY

February 5, 1935

White

White

New York

STANLEY

STANLEY

STANLEY

STANLEY

STANLEY - The Clinical Center, Washington, D.C.

Left Ventricular Failure

Acquired Aortic Stenosis

2 hours  
6 weeks

August 6, 1935

August 10, 1935

8/11/35

The Clinical Center, Washington, D.C.

RICHARD P. ANTHONY, M.D.

STANLEY - The Clinical Center, Washington, D.C.

August 12, 1935

STANLEY

STANLEY

STANLEY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be completed by the hospital or attending physician. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please move carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9295

## CERTIFICATE OF DEATH

09286

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>178 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Bloomfield</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>24 Hazelwood Road</b> d. STREET ADDRESS <b>24 Hazelwood Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Mary Agnes Grant</b>		<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>24</b> Year <b>19 61</b>	
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>April 6, 1894</b>	
<b>9. AGE</b> (In years last birthday) <b>67 yrs.</b>		<b>10. IF UNDER 1 YEAR</b> Months <b>5</b> Days <b>7</b> Hours <b>0</b> Min. <b>0</b>	
<b>11a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>11b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>Bernard Maguire</b>	
<b>14. MOTHER'S MAIDEN NAME</b> <b>Margaret Kerwin</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>	
<b>16. SOCIAL SECURITY NO.</b> <b>136-01-9906</b>		<b>17. INFORMANT</b> <b>The Medical Record</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Widespread Staphylococcal Septicemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Abdominal abscess associated with segmental necrosis of transverse colon</b> DUE TO (c) <b>Recurrent pancreatitis</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>5 - 7 days</b> <b>5-7 days</b> <b>several months</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Sjogrens Syndrome (years) Chronic Osteomyelitis, left femur (1 1/2 yrs.)</b>			
<b>22a. SIGNATURE</b> <b>William T. Butler, M.D.</b>		<b>22b. DATE</b> <b>8/25/61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>WILLIAM T. BUTLER, M.D.</b>		<b>22d. ADDRESS</b> <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>8/28/61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Holy Cross Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>North Arlington, N. J.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert A. Pumphrey</b>		<b>25a. REC'D BY REGISTRAR</b> <b>AUG 30 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hanes</b>			

(M)

2222

48222

Post-mortem

New Jersey

Botanica

178 days

Unidentified

The Clinical Center, Bethesda, Md.

24 Armstrong Road

May

June

June

August

24

21

Female - White

April 6, 1904

Hagerfield

None

New York

U.S.A.

Forward to me

Forward to me

135-01-100 The Clinical Center, Bethesda, Md., Maryland

Witnesses: Campbell, Campbell

Abdominal aortic aneurysm associated with degenerative atherosclerosis 2-7 days

Recent aneurysm

Stigmata (years) Chronic Osteomyelitis, left femur (12 yrs.)

February 27, 1904

August 24

8/22/04  
The Clinical Center, National Institutes of Health, Bethesda, Md., Maryland

WILLIAM T. BUTLER, M.D.

Butler, 8/22/04 Holy Cross Cemetery, Mount Arlington, N.J.

Robert A. Murphy, Bethesda, Maryland

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9296

## CERTIFICATE OF DEATH

09287

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>21 hrs. 25 mins.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Mont.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>8516-Irvington Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JOHN B GRIFFITH</b>				4. DATE OF DEATH <b>8 27 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 9, 1907</b>	
9. AGE (In years last birthday) <b>53</b> yrs.		10. IF UNDER 1 YEAR Months <b>27</b> Days <b>1</b>		11. IF UNDER 24 HRS. Hours <b>27</b> Min. <b>1</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Admin. Assistant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Red Cross</b>			
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Benjamin Griffith</b>				14. MOTHER'S MAIDEN NAME <b>Laura Jones</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>			
17. INFORMANT <b>Cleo Griffith-wife-same 2d</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Adenocarcinoma of Lung</b> DUE TO (b) <b>a metastases to kidney</b> DUE TO (c) <b>Adrenals &amp; Spleen</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Interval between onset and death</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/15/61</b> to <b>8/27/61</b> , that (I) (we) last saw the deceased alive on <b>8/27/61</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>W. T. Joyce</b> M.D.				22b. DATE SIGNED <b>8/28/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>W. T. Joyce</b>				22d. ADDRESS <b>8106 Maple Ridge Rd. Beth. Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/30/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR <b>AUG 30 '61</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

3232

(M)

(I)

Medical Hospital

John

8

CRIVIN

Sept. 1, 1907

White

Assistant

Red Cross

Pennsylvania

Benjamin Griggs

Laure Jones

Unknown Class Officer - White - same to

Laure Jones

Bartholomew County

Bartholomew County

Robert A. Humphrey

Bartholomew County

White Male - same to

Bartholomew County



1  
FOR STATE  
HEALTH DEPT.  
M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9297 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09288

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY in lb <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>216 Wayne Place, S.E.</b> d. STREET ADDRESS <b>47X-3</b>	
3. NAME OF DECEASED (Type or print) <b>Virginia Lee Hartford</b>		4. DATE OF DEATH Month Day Year <b>August 20, 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 15, 1943</b>
9. AGE (In years last birthday) <b>18</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>18</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harold Leroy Hartford Weaver</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Trail</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year of departure from service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Shirley Fookes</b>		Address <b>3872-Gth St., S.E., Wash DC</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC TAMPONADE</b> DUE TO (b) <b>TRAUMATIC LACERATION, RIGHT AND LEFT CARDIAC</b> DUE TO (c) <b>AUTO ACCIDENT</b> CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>815X</b> <b>AURICULAR APPENDAGE.</b> <b>SUDDEN</b> <b>SUDDEN</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Struck by auto while riding in rear of motorcycle</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Struck by auto while riding in rear of motorcycle</b>	
20c. TIME OF INJURY Month, Day, Year <b>2:30 - 8-20-1961</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>street</b>		20f. (City or town) (County) (State) <b>Silver Spring Monty Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschant</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>FRANK J. Broschant</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <b>8-20-61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/26/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CON</b>		22d. LOCATION (City, town, or country) (State) <b>COLMAR MARSH PR GEO CO</b>	
23. FUNERAL DIRECTOR <b>W.W. Chambers Co</b>		ADDRESS <b>517-1197 SE. WASH DC</b>	
24a. REC'D BY REGISTRAR <b>AUG 24 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

NEW STATE  
JULY 1941



Montgomery

Takoma Park

DOA

Washington

Washington Sanatorium Hospital 214 Wayne Place, S.E.

Virginia Lee Howard August 20, 1941

X

Female white June 12, 1943 18

Washington, D.C. N.Y.N.

Virginia Trail

Harold Lloyd Howard

No

Shirley Fookes 3812-CHAST, S.E. DC

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9298

## CERTIFICATE OF DEATH

09289

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>			
c. LENGTH OF STAY IN 1b <u>47X-2</u>				d. STREET ADDRESS <u>6918 WILLOW STREET, N.W.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON SANITARIUM &amp; HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Augustus</u> Last <u>Harrison</u>				4. DATE OF DEATH Month <u>8</u> Day <u>12</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month <u>4</u> Day <u>15</u> Year <u>1883</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired W &amp; J Sloan</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FURNITURE STORE</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Takoma Park, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George Harrison</u>				14. MOTHER'S MAIDEN NAME <u>Alice Johnson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes give year or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>578-03-0935</u>			
17. INFORMANT <u>JOSEPH A. HILLEBERT, 7510 CARROLL AVE., TAKOMA PARK, MD.</u>				18. ADDRESS <u>Takoma Park, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Gastric Hemorrhage</u> 151X DUE TO (b) <u>Carcinoma of Stomach (cardia)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>6 mo 2</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 11 1961</u> to <u>Aug 12 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug 11 1961</u> , and that death occurred at <u>7:30 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>James H. White M.D.</u>				22b. DATE SIGNED <u>8-12-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>James H. White</u>				22d. ADDRESS <u>7717 Carroll Ave Takoma Park, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/14/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		23d. LOCATION (City, town or county) (State) <u>Southwest Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters 254 Cedar St. N.W. Wash, D.C.</u>				25a. REC'D BY REGISTRAR <u>AUG 16 '61</u>			
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9299

03290

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>1823 P. St. N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Aubrey Elbert Haynes</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>August 21 19 61</b>	
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Caucasian</b>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>1-2-95</b>	
<b>9. AGE</b> (In years last birthday) <b>66 yrs.</b>		<b>IF UNDER 1 YEAR</b> Months Days <b>66</b>	
<b>IF UNDER 24 HRS.</b> Hours Min. <b>66</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Officer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>U. S. Navy</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>North Carolina</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>John Lindsey Haynes</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Molly Moore</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		<b>16. SOCIAL SECURITY NO.</b> <b>263 16 2248</b>	
<b>17. INFORMANT</b> <b>(W) Elizabeth M. Haynes, Same as #2 above</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardio-respiratory cessation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>congestive heart failure</b> (c) <b>rheumatic mitral stenosis and insuff.</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b> <b>Taeniasis cinchocinae &amp; ascaris</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that</b> (this hospital) attended the deceased from <b>August 7, 1961</b> , to <b>August 21, 1961</b> , that (we) last saw the deceased alive on <b>August 21, 1961</b> , and that death occurred at <b>1:10 PM</b> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>Joseph H. Eusterman</b> M.D.		<b>22b. DATE</b> <b>21 August 1961</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>JOSEPH H. EUSTERMAN, LT MC USN</b>		<b>22d. ADDRESS</b> <b>U. S. Naval Hospital</b> <b>NNMC Bethesda, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Cremation</b>		<b>23b. DATE THEREOF</b> <b>23 August 1961</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Lee Funeral Home</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Washington D. C.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Lee Funeral Home, 4th &amp; Mass. Washington, D. C.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>AUG 24 '61</b>	

9292

11520



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9300

## CERTIFICATE OF DEATH

09291

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>344 Howard Avenue</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>344 Howard Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Edwin D. Henley</u>		<b>4. DATE OF DEATH</b> Last <u>Henley</u> Month <u>Aug.</u> Day <u>17</u> Year <u>1961</u>		<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u>			
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Aug. 19, 1892</u>		<b>9. AGE</b> (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Ret. Supt. Public Works</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Town of Rockville</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Montgomery Co. Maryland</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Frank Henley</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Ohler Peddicord</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>214-18-7218</u>		<b>17. INFORMANT</b> <u>Beatrice L. Henley</u> Address <u>344 Howard Avenue, Rockville, Maryland</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO <u>8 MONTHS</u> (c) <u>GENERALIZED ARTERIO SCLEROSIS</u> DUE TO <u>20 YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS - UREMIA</u>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>20g. (County)</b>		<b>20h. (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>NOV. 1957</u> <b>to</b> <u>AUGUST 18, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>AUGUST 16, 1961</u> , <b>and that death occurred at</b> <u>3:00 A.M.</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Gordon S. Rosenberger</u> M.D.		<b>22b. DATE SIGNED</b> <u>August 22, 1961</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Gordon S. Rosenberger</u>			
<b>22d. ADDRESS</b> <u>310 W. Montgomery Ave, Rockville, Md.</u>		<b>22e. ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>22f. MED. DIRECTOR</b> <input type="checkbox"/> <b>22g. STAFF PHYS.</b> <input type="checkbox"/>		<b>22h. DATE SIGNED</b> <u>August 22, 1961</u>			
<b>23a. BURIAL, CREMATION, REMOVAL, (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>8/19/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Forest Oak</u>			
<b>23d. LOCATION</b> (City, town or county) <u>Gaithersburg, Montgomery Co. Md.</u>		<b>23e. (State)</b>		<b>23f. (Country)</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Tyson Wheeler Funeral Home</u>		<b>24a. ADDRESS</b> <u>1331 - E. Montg. Ave. Rockville, Md.</u>		<b>24b. RECD. BY REGISTRAR</b> <u>Aug 21 1961</u>			
<b>24c. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kneass</u>		<b>24d. DATE</b>		<b>24e. REGISTRAR'S SIGNATURE</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

(M)

(1)

Montgomery  
Rockville

344 Howard Avenue

Edwin

Male White

Ret Capt Public Works  
Frank Henley

No

Montgomery  
Rockville

344 Howard Avenue

Henley

Aug 19, 1933

Town of Rockville, Montgomery Co, Maryland  
Oliver Robinson

344-18-3518 Certificate of Birth

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Forest Oak

8/1/31

8/1/31

Rockville, Md.

Montgomery Co, Md.

Montgomery Co, Md.

8/1/31

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**9301**

## CERTIFICATE OF DEATH

**09292**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b <u>15</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wheaton Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>13407 Sherwood Forest Dr</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Boyd L. Henry</u>		<b>4. DATE OF DEATH</b> Last <u>Henry</u> Month <u>8</u> Day <u>16</u> Year <u>19 61</u>		<b>5. SEX</b> <u>MALE</u> <b>6. COLOR OR RACE</b> <u>W</u>			
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>B. DATE OF BIRTH</b> <u>Dec. 31, 1889</u>		<b>9. AGE</b> (In years last birthday) <u>71</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MARTINSBURG W. VA</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>DANIEL L. HENRY</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>MARY MACBEE</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes, give war and dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>  </u>		<b>17. INFORMANT</b> Address <u>MRS. MARJORIE HALL 13407 Sherwood Forest Dr</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ARTERIO SCLEROSIS</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>CEREBRO VASCULAR ACCIDENT</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>							
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19 61</u> Hour a.m. <u>  </u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>			
<b>20f. (City or town)</b> <u>  </u> <b>(County)</b> <u>  </u> <b>(State)</b> <u>  </u>		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>8/6</u> , 19 <u>61</u> to <u>8/16</u> , 19 <u>61</u> ; that (I) (we) last saw the deceased alive on <u>8/6</u> , 19 <u>61</u> , and that death occurred at <u>3:35 AM</u> , from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <u>H. W. Stout M.D.</u>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>8/16/61</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>H.W. STOUT</u>		<b>22d. ADDRESS</b> <u>10011 GEORGIA AVE SILVER SPRING MD</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>  </u>		<b>23b. DATE THEREOF</b> <u>8-19-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill</u>			
<b>23d. LOCATION</b> (City, town or county) <u>  </u> <b>(State)</b> <u>  </u>		<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <u>300 4th St NE Wash DC</u>					
<b>25a. REC'D BY REGISTRAR</b> <u>  </u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>		<b>DATE</b> <u>AUG 18 '61</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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1920 January

2 Jan 1920

1920 January 1920

Box

W. H.

Charles L. Henry

My dear Mr. Henry

I have just received

your letter of the 1st inst.

and am glad to hear

from you and that you are

well and happy. I am

very glad to hear that

you are all well and

happy. I am very glad

to hear from you and

that you are all well

and happy. I am very

glad to hear from you

and that you are all

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9302  
CERTIFICATE OF DEATH  
09293

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			
c. LENGTH OF STAY IN 1b <b>708 Philadelphia Avenue</b>				d. STREET ADDRESS <b>8106 Tahona Drive</b>			
4. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cur-Lu Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HERMAN</b> Middle <b>L.</b> Last <b>HERMANSON</b>				4. DATE OF DEATH Month <b>Aug</b> Day <b>1</b> Year <b>1961</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/24/82</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Able, Finland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Herman L. Hermanson</b>				14. MOTHER'S MAIDEN NAME <b>Katherine----</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>578-09-1663</b>		17. INFORMANT Address <b>Mrs. Lillian C. Donaldson same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis c/d. hemiplegia</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>Senility</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>several years</b> <b>" "</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic pyelonephritis</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>e.m.</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 1958</b> to <b>Aug 1, 1961</b> , that (I) <del>was</del> last saw the deceased alive on <b>Aug 1, 1961</b> , and that death occurred <b>2:00 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>IRWIN I. YAGER M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Aug 1, 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>IRWIN I. YAGER M.D.</b>				22d. ADDRESS <b>3055-16th St. N.W., WASH. D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>8/4/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Company</b>				25. REC'D BY REGISTRAR <b>20061 14th St. N.W. Washington 9, D.C.</b> <b>AUG 3 '61</b>			
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

02303

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TO HOSPITAL OR AN ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

12  
9303  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
09294

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47 X -3</b> d. STREET ADDRESS <b>5818 Sherrier Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>Bertha Virginia Hiley</b>		4. DATE OF DEATH Month <b>August</b> Day <b>4</b> Year <b>19 61</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 1, 1912</b>		9. AGE (In years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Ohio</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Albert Robertson</b>				14. MOTHER'S MAIDEN NAME <b>Clara Sheets</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unavailable</b>				17. INFORMATION <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acidosis</b> <b>4 33.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prolonged anoxia and temporary cardiac arrest</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Myasthenia gravis</b> INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>24 hours</b>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>August 3, 1961</b> to <b>August 4, 1961</b> that (I) (we) last saw the deceased alive on <b>August 4, 1961</b> , and that death occurred at <b>7:32 PM</b> from the causes and on the date stated above.																			
22a. SIGNATURE <b>Edward L. Eyerman</b> M.D.				22b. DATE SIGNED <b>8/5/61</b>				22c. PHYSICIAN'S NAME (Type) <b>EDWARD L. EYERMAN, M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>8/7/1961</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Bladensburg, Md.</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Sawlerson</b>				ADDRESS <b>1756 Pa. Ave. NW, DC</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 8 '61</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

08394

08394

M

Department of Columbia

Department of Columbia

Washington

1 day

Rehearsal

2010 Theater Place

The National Center, Bethesda, Md.

at 10:00 a.m.

Miss

Virginia

Berlin

September 1, 1912

Female

10:00

10:00

10:00

10:00

Class Notes

Albert Johnston

The Medical Record

Investigation

10:00

10:00

10:00

Colored notes and papers carried away

Investigation

August 3, 1912

August 1, 1912

10:00

The National Center, National Institute of Health, Bethesda, Md.

Edward L. Evans, M.D.

Division of Research, National Institute of Health

Health and Safety, Division of Research, National Institute of Health

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9304

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09295

1 ~~2~~  
**FOR STATE HEALTH DEPT.**  
**M**  
 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.  
 VS. A15ME  
 5M 9/60

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY in 1b <u>life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R-609 Norwood Rd</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>32 Rockville</u> d. STREET ADDRESS <u>R 609 Norwood Rd</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Elgar Lenwood Holland</u>		<b>4. DATE OF DEATH</b> <u>Aug 13 1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>col</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>9-16-1918</u>	<b>9. AGE</b> (In years, last birthday) <u>42</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>		
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>md</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. E</u>			
<b>13. FATHER'S NAME</b> <u>Clarence Holland</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Martha Nickens</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u> (If yes give war or dates of service) <u>  </u>		<b>16. SOCIAL SECURITY NO.</b> <u>  </u>		<b>17. INFORMANT</b> Address <u>  </u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon monoxide poisoning</u> <u>973.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Hose attached to exhaust extending into car</u>							
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>8-10-61</u> Hour a.m. <u>3</u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>home</u>			
<b>20f. (City or town)</b> <u>Rockville</u>		<b>20g. (County)</b> <u>Monty</u>		<b>20h. (State)</b> <u>md</u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschant</u>			<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschant</u>			<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>			<b>22b. DATE THEREOF</b> <u>8/15/61</u>				
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Pleasant</u>			<b>22d. LOCATION (City, town, or country)</b> <u>Norbeck, Md.</u>				
<b>23. FUNERAL DIRECTOR</b> ADDRESS <u>Robert L. Snowden</u> <u>Rockville, Md.</u>			<b>24a. REC'D BY REGISTRAR</b> <u>AUG 23 '61</u>				
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Haine</u>			<b>DATE SIGNED</b> <u>8-13-61</u>				

10880

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9305

CERTIFICATE OF DEATH

Item 14 File 9293 8/28/61 ink

08296

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>MONTGOMERY</i>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SILVER SPRING</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) IN INSTITUTION <i>Dr. Dean Gardens Nursing Home</i>		d. STREET ADDRESS <i>19215 WENDELL STREET</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>MARIAN</i> Middle <i>W.</i> Last <i>HOUCK</i>		4. DATE OF DEATH Month <i>Aug</i> Day <i>21</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>FEB. 11, 1884</i>
9. AGE (In years lost birthday) <i>77</i> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Portsmouth, New Hamp.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Frank W. Hogan</i>		14. MOTHER'S MAIDEN NAME <i>Helen unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Wm. L. HOUCK, Jr. (same as #2)</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>331X</i> DUE TO <i>Senile Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <i>10 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Aug 1958</i> to <i>21 Aug 1961</i> , that (I) (we) last saw the deceased alive on <i>1 Aug 1961</i> , and that death occurred at <i>417</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>M. B. Queen M.D.</i> M.D.		22b. DATE SIGNED <i>21 Aug 1961</i>	
22c. PHYSICIAN'S NAME (Type) <i>M. B. QUEEN M.D.</i>		22d. ADDRESS <i>7112 Willow Ave TAKOMA PARK, MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Aug. 24, 1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Prince Georges County, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters</i>		25a. REC'D BY REGISTRAR <i>Arthur L. Hanna</i>	
ADDRESS <i>254 Canall St NW D.C.</i>		25b. REGISTRAR'S SIGNATURE	
DATE <i>AUG 24 '61</i>			

(over)

8/22/61

Mr. Frank J. Broschart, Dep. Med. Examiner notified and  
authorized Mr. G. B. Queen to sign certificate



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9306 CERTIFICATE OF DEATH 09297											
1. PLACE OF DEATH a. COUNTY Montgomery						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Triangle					
c. LENGTH OF STAY IN b 10 days						d. STREET ADDRESS 36 A Purvis Drive					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Judy Lee James						4. DATE OF DEATH August 10 1961					
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-4-40		9. AGE (In years last birthday) 20 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ernest Hymer						14. MOTHER'S MAIDEN NAME Margaret Braun					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 514-40-1063		17. INFORMANT (H) Jack "J" James same as #2 above					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphoblastic leukemia, acute</u> 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 10 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that <del>he</del> (this hospital) attended the deceased from <u>July 31</u> 19 <u>61</u> to <u>August 10</u> 19 <u>61</u> , that <del>he</del> (we) last saw the deceased alive on <u>August 10</u> 19 <u>61</u> , and that death occurred at <u>8:00 AM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Lewis Ned Cahill</u>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED August 10, 1961			
22c. PHYSICIAN'S NAME (Type) Lewis Ned Cahill, LCDR MC USN						22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shippment				23b. DATE THEREOF August 10, 1961		23c. NAME OF CEMETERY OR CREMATORY Municipal Cemetery		23d. LOCATION (City, town or county) Bonner Springs		(State) Kansas	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u> Rockville, Md. Tyson Wheeler, Rockville, Md.						25a. REC'D BY REGISTRAR DATE <u>AUG 11 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Curtis S. Evans</u>			

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(1) (2)

U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital

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U. S. Naval Hospital

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

9307

15298

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY in lb <b>24 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>District of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b> d. STREET ADDRESS <b>1561 33rd St. N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <b>Howard Lobdell Jennings</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>August 16 19 61</b>									
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Caucasian</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>September 26, 1900</b>		<b>9. AGE</b> (In years last birthday) <b>60</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Officer</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>U. S. Navy</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Massachusetts</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Ralph Jennings</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Belle Hutchin</b>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW II</b>				<b>16. SOCIAL SECURITY NO.</b> <b>577 26 6210</b>		<b>17. INFORMANT</b> <b>Gloria Jennings</b> Same as #2 above							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma, Right Lung</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>one month</b>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>21c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <b>19</b>				<b>22d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>22e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>22f. (City or town)</b> <b>July 23, 19 61 to August 16, 19 61</b>		<b>(County)</b> <b>2:25 PM</b>		<b>(State)</b>	
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 23, 19 61</b> to <b>August 16, 19 61</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>August 16, 19 61</b> , and that death occurred at <b>2:25 PM</b> , from the causes and on the date stated above.													
<b>22a. SIGNATURE</b> <b>D. L. KELLEY</b>						<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>		<b>22b. DATE</b> <b>August 16, 1961</b>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>D. L. KELLEY, LT MC USN</b>						<b>22d. ADDRESS</b> <b>U. S. Naval Hospital, Bethesda, Md.</b>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>August 21 1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b>				<b>23d. LOCATION</b> (City, town or county) (State) <b>Arlington Va.</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>DeVol 2224 Wisconsin Ave. N.W. Washington, D. C.</b>						<b>25a. REC'D BY REGISTRAR</b> <b>DATE AUG 21 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Kraus</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

202

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155-10243

2011年10月

*E. coli*

2408

2002/03/06 10:13

REC-327-315-36

FS 4716,

1507 1508 1509 1510 1511 1512 1513 1514 1515 1516 1517 1518 1519 1520 1521 1522 1523 1524 1525 1526 1527 1528 1529 1530 1531 1532 1533 1534 1535 1536 1537 1538 1539 1540 1541 1542 1543 1544 1545 1546 1547 1548 1549 1550 1551 1552 1553 1554 1555 1556 1557 1558 1559 1560 1561 1562 1563 1564 1565 1566 1567 1568 1569 1570 1571 1572 1573 1574 1575 1576 1577 1578 1579 1580 1581 1582 1583 1584 1585 1586 1587 1588 1589 1590 1591 1592 1593 1594 1595 1596 1597 1598 1599 1600 1601 1602 1603 1604 1605 1606 1607 1608 1609 1610 1611 1612 1613 1614 1615 1616 1617 1618 1619 1620 1621 1622 1623 1624 1625 1626 1627 1628 1629 1630 1631 1632 1633 1634 1635 1636 1637 1638 1639 1640 1641 1642 1643 1644 1645 1646 1647 1648 1649 1650 1651 1652 1653 1654 1655 1656 1657 1658 1659 1660 1661 1662 1663 1664 1665 1666 1667 1668 1669 1670 1671 1672 1673 1674 1675 1676 1677 1678 1679 1680 1681 1682 1683 1684 1685 1686 1687 1688 1689 1690 1691 1692 1693 1694 1695 1696 1697 1698 1699 1700 1701 1702 1703 1704 1705 1706 1707 1708 1709 1710 1711 1712 1713 1714 1715 1716 1717 1718 1719 1720 1721 1722 1723 1724 1725 1726 1727 1728 1729 1730 1731 1732 1733 1734 1735 1736 1737 1738 1739 1740 1741 1742 1743 1744 1745 1746 1747 1748 1749 1750 1751 1752 1753 1754 1755 1756 1757 1758 1759 1760 1761 1762 1763 1764 1765 1766 1767 1768 1769 1770 1771 1772 1773 1774 1775 1776 1777 1778 1779 1780 1781 1782 1783 1784 1785 1786 1787 1788 1789 1790 1791 1792 1793 1794 1795 1796 1797 1798 1799 1800 1801 1802 1803 1804 1805 1806 1807 1808 1809 1810 1811 1812 1813 1814 1815 1816 1817 1818 1819 1820 1821 1822 1823 1824 1825 1826 1827 1828 1829 1830 1831 1832 1833 1834 1835 1836 1837 1838 1839 1840 1841 1842 1843 1844 1845 1846 1847 1848 1849 1850 1851 1852 1853 1854 1855 1856 1857 1858 1859 1860 1861 1862 1863 1864 1865 1866 1867 1868 1869 1870 1871 1872 1873 1874 1875 1876 1877 1878 1879 1880 1881 1882 1883 1884 1885 1886 1887 1888 1889 1890 1891 1892 1893 1894 1895 1896 1897 1898 1899 1900 1901 1902 1903 1904 1905 1906 1907 1908 1909 1910 1911 1912 1913 1914 1915 1916 1917 1918 1919 1920 1921 1922 1923 1924 1925 1926 1927 1928 1929 1930 1931 1932 1933 1934 1935 1936 1937 1938 1939 1940 1941 1942 1943 1944 1945 1946 1947 1948 1949 1950 1951 1952 1953 1954 1955 1956 1957 1958 1959 1960 1961 1962 1963 1964 1965 1966 1967 1968 1969 1970 1971 1972 1973 1974 1975 1976 1977 1978 1979 1980 1981 1982 1983 1984 1985 1986 1987 1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

6. 1997

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Pages 3 and 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9308											
CERTIFICATE OF DEATH											
09299											
1. PLACE OF DEATH COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>				d. STREET ADDRESS <b>810 Johnson Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mary</b>		First		Middle <b>Emma</b>		Last <b>Jennings</b>		4. DATE OF DEATH Month <b>August</b>		Day <b>10</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 28, 1899</b>		9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months <b>2</b> Days <b>12</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Telephone Operator</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Levi C. Gill</b>				14. MOTHER'S MAIDEN NAME <b>Augusta E. Wilson</b>				Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. (If assigned a war or defense service)				17. INFORMANT <b>Washington Sanitarium and Hospital</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO <b>Cerebral Hemorrhage</b> <b>Acute Passive Congestion - cardiac</b> <b>Hypostatic Pneumonia</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 days</b> <b>3 days</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 1960</b> to <b>Aug. 10, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 9, 1961</b> , and that death occurred at <b>2:40</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Robert A. Hare</b>				M.D. <b>Robert A. Hare MD</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Aug 10, 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert A. Hare MD</b>				22d. ADDRESS <b>7600 Carroll Ave., T.P. Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/12/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Prince George's Co. Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey, Inc.</b>				ADDRESS <b>Silver Spring, Maryland</b>				25a. REC'D BY REGISTRAR <b>AUG 16 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hunt</b>	

VR A15 (4)  
15M 9/60

(M)

2308

Montgomery

Takoma Park

Washington Sanitarium and Hospital

Mary

Emma Jennings

Female Two to

Attended - Telephone Operator

Levi C. Gill

No

Montgomery

Montgomery

Silver Spring

3 days

810 Johnson Avenue

August 10

Emma Jennings

June 22, 1929

Maryland

Audrey E. Wilson

Washington Sanitarium and Hospital

2308



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9309

## CERTIFICATE OF DEATH

09300

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>30 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>D.C.</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u> d. STREET ADDRESS <u>419 Constitution Ave. N.E.</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Ira Ellsworth Johnson</u>				<b>4. DATE OF DEATH</b> Month <u>August</u> Day <u>22</u> Year <u>1961</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>8-27-02</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Projectionist</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Highland Theater</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Washington D.C.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Albanus Stevenson Tudor Johnson</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Edith Yoder</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>yes</u> <b>16. SOCIAL SECURITY NO.</b> <u>216-09-9263</u>				<b>17. INFORMANT</b> <u>son-in-law</u> Address <u>13914 Parkland Dr. Rockville Md.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Due to</u> } (c) <u>Due to</u>				<b>19. INTERVAL BETWEEN ONSET AND DEATH</b> <u>10-15 min</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <u>Ecologen Disease.</u>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>9</u> a.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital)</b> attended the deceased from <u>12/15</u> to <u>8/22</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8/22</u> , 19 <u>61</u> , and that death occurred at <u>3:15 PM</u> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>W.B. Wardrop md</u> M.D.				<b>22b. ADDRESS</b> <u>800 Pershing Drive. Silver Spring Md.</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>W.B. WARDROP. M.D.</u>				<b>22d. ADDRESS</b> <u>800 Pershing Drive. Silver Spring Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>8/25/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rock Creek Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Washington, D.C.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Raymond H. Ziskin</u>				<b>25a. REC'D BY REGISTRAR</b> <u>Arthur S. Thomas</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Warner E. Pumphrey, Inc.</u>				<b>25c. DATE</b> <u>AUG 25 '61</u>			

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(M)

W.D. LARSON, JR.  
1000 1st St. N.E.  
Washington, D.C.  
20002

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9310

CERTIFICATE OF DEATH

09301

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY in 1b <b>1 Day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b> d. STREET ADDRESS <b>14-A West Del Ray Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Jewell Gwendolyn Johnson</b>			4. DATE OF DEATH Month <b>August</b> Day <b>21</b> , Year <b>19 61</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>May 28, 1918</b>		9. AGE (In years birth day) <b>43</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Research analyst</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>		11. BIRTHPLACE (County & State, or foreign country) <b>North Dakota</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Arthur J. Johnson</b>			
14. MOTHER'S MAIDEN NAME <b>Georgia Nelson</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. <b>468-12-4502</b>		17. INFORMANT <b>The Medical Records</b> <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subdural Hematoma</b> DUE TO 204-3 Conditions, if any, which gave rise to immediate cause (b) <b>Acute Myelogenous Leukemia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>2 Days</b> <b>10 Months</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>August 21, 1961</b>		20g. (County) <b>Washington, D. C.</b>		20h. (State) <b>August 21, 1961</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>August 21, 1961</b> to <b>August 21, 1961</b> , that (I) (we) last saw the deceased alive on <b>August 21, 1961</b> , and that death occurred at <b>4:32 P.M.</b> on the causes and on the date stated above.					
22a. SIGNATURE <b>Robert H. Levin</b>		22b. DATE <b>8/22/61</b>		22c. PHYSICIAN'S NAME (Type) <b>ROBERT H. LEVIN, M.D.</b>	
22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
23b. DATE THEREOF <b>8/23/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J.H. Hines Co.</b>		25a. REC'D BY REGISTRAR <b>AUG 23 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

VR A15 4  
15M 9/60

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the Clinical Center, National Institutes of Health, Bethesda, Md. 20892

Dr. Robert H. Lavin, M.D.

Director, Division of Hematology

Department of Medicine

University of Maryland School of Medicine

685 North Wolfe Street

Baltimore, Maryland 21201

Re: [illegible]

Enclosed for you are two copies of a letterhead memorandum dated and captioned as above.

Very truly yours,

[illegible signature]

Enclosure

Specialist Hematology

Acute Myelogenous Leukemia

10 copies

11:32 a.m.

11:32 a.m.

Robert H. Lavin, M.D.

The Clinical Center, National Institutes of Health, Bethesda, Md. 20892

Rock Creek Community Center

Washington, D.C.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

9311

09302

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>R.F.D. #1 Gaithersburg, Md</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ammons Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Garfield</b> Last <b>Johnson</b>				4. DATE OF DEATH Month <b>August</b> Day <b>12</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Col</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/18/1903</b>	
9. AGE (In years lost birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months <b>57</b> Days <b>0</b> Hours <b>0</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Joseph Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Georgia Hayes</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>331X</b>		17. INFORMANT <b>Mrs Kathleen Offutt (Daughter)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO <b>C.V.A.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension</b> DUE TO (c) <b>Hypertension</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7/15</b> 19 <b>61</b> to <b>8/12</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>8/11</b> 19 <b>61</b> , and that death occurred at <b>3:45 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Luciano I. Leal</b>				22b. DATE SIGNED <b>8/12/61</b>		22c. PHYSICIAN'S NAME (Type) <b>Luciano I. Leal</b>	
22d. ADDRESS <b>Gaithersburg, Md</b>				22e. ADDRESS <b>Gaithersburg, Md</b>		22f. ADDRESS <b>Gaithersburg, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/15/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rocky Hill Cem</b>		23d. LOCATION (City, town, or county) (State) <b>Clarksburg, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>				25a. REC'D BY REGISTRAR <b>Arthur S. Frank</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

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## References

10/24



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
9312					09303				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY Montgomery					a. STATE Pennsylvania				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Masontown				
c. LENGTH OF STAY in 1b 6 days					d. STREET ADDRESS 539 N. Main St.				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last Albert Jack Kermes					Month Day Year August 9 19 61				
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-16-28		9. AGE (in years last birthday) 32 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Albert John Kermes					14. MOTHER'S MAIDEN NAME Rose Roth				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes					16. SOCIAL SECURITY NO. 163-22-5705				
17. INFORMANT WW II					Address (W) Marilyn G. Kermes same as #2 above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute stenosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>rheumatic heart disease</u> DUE TO (c) <u>undetermined</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from <u>August 3</u> , 19 <u>61</u> to <u>August 9</u> , 19 <u>61</u> that <u>xx</u> (we) last saw the deceased alive on <u>August 9</u> , 19 <u>61</u> , and that death occurred <u>11:00 AM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>B. H. Rice</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>August 10, 1961</u>		
22c. PHYSICIAN'S NAME (Type) B. H. RICE, LT MC USN					22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF August 14, 1961		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) Arlington		(State) Va.
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, 7559 Wisconsin Ave, Bethesda, Md.					25a. REC'D BY REGISTRAR DATE <u>AUG 14 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hane</u>		

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RECEIVED  
JAN 11 1957  
U.S. DEPARTMENT OF THE ARMY  
WASHINGTON, D.C.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9313

09304

1. PLACE OF DEATH e. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		d. STREET ADDRESS <b>3335 - Military Rd., N. W.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Herbert F. Keyser</b>				4. DATE OF DEATH Month <b>August</b> Day <b>24</b> Year <b>19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/5/1883</b>	9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Teacher</b>		11. BIRTHPLACE (County & State, or foreign country) <b>North Sutton, N. Hampshire</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Fred Keyser</b>				14. MOTHER'S MAIDEN NAME <b>Grace Shattuck</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-12-7827</b>		17. INFORMANT Address <b>Charles H. Omo 5514 Cedar Pkwy. Ch. Ch., Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>332 X</b> DUE TO <b>Cerebral Thrombosis</b> <b>Cerebral Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) (c)						INTERVAL BETWEEN ONSET AND DEATH <b>34 da</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>8-24</b> <b>1961</b> to <b>8-24</b> <b>1961</b> that (I) saw the deceased alive on <b>8-24</b> <b>1961</b> , and that death occurred at <b>9A</b> M, from the causes and on the date stated above.							
22. SIGNATURE <b>Jonathan Williams</b> 22c. PHYSICIAN'S NAME (Type) <b>Jonathan Williams, M.D.</b>				22d. ADDRESS <b>1726 "M" Street, N.W. Washington D. C.</b>		22b. DATE SIGNED <b>8/24/61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/26/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bowman's Chapel Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Cassville, Pennsylvania</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR <b>AUG 28 61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. [Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

02304

02304

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Washington Hospital

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Washington, D.C.

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The law requires that this certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9314

CERTIFICATE OF DEATH

Item 2 Film G293 8/22/61 mh

09305

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY IN lb <b>9 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanitizrium + Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
3. NAME OF DECEASED (Type or print) <b>Alice Elizabeth Kidder</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hypocissville Berkley</b>		d. STREET ADDRESS <b>78 San Mateo Rd.</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>4-10-81</b>		9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (County & State, or foreign country) <b>Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Fred H. Schriber</b>	
14. MOTHER'S MAIDEN NAME <b>Esther Wheat</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Address</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY INFARCT</b> DUE TO (b) <b>EMBOLISM</b> DUE TO (c) <b>GENERALIZED ATHEROSCLEROSIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>BRONCHOPNEUMONIA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs (approx)</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>31 JULY 1961</b>		20g. (County) <b>8-10</b>		20h. (State) <b>1961</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>31 JULY 1961</b> to <b>8-10</b> , 19 <b>61</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>8-10</b> , 19 <b>61</b> , and that death occurred at <b>6:05 PM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Morrill C. Quinnam Jr.</b> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>MORRILL C. QUINNAM JR.</b>		22d. ADDRESS <b>7600 CARROLL AVE. TAKOMA PARK</b>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>8/11/61</b>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery Prince Georges County Md.</b>	
23d. LOCATION (City, town or county) <b>Prince Georges County Md.</b>		23e. REC'D BY REGISTRAR <b>Arthur Walters</b>		23f. REGISTRAR'S SIGNATURE <b>Arthur Walters</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur Walters</b>		24a. ADDRESS <b>254 Carroll St. N.W. Wash. DC</b>		24b. DATE <b>AUG 14 '61</b>	

02303

3314

(M)

Montgomery

Tokoro Park

Washington Sanatorium + Hospital

Place

Eligible

Kidney

Female with

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4-10-27

Thompson

Thompson

Fred H. Schiller

Edith Whit

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31 July

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9315

09306

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>39 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>Kentucky</b> f. COUNTY <b>Anchorage</b> d. STREET ADDRESS <b>55x-3</b> g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <b>Francis Sebastian Kieren</b>		<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>23</b> Year <b>19 61</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Caucasian</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>3-31-88</b>		
<b>9. AGE</b> (In years last birthday) <b>73 yrs.</b>		<b>10. IF UNDER 1 YEAR</b> Months <b>73</b> Days <b>0</b>		<b>11. IF UNDER 24 HRS.</b> Hours <b>0</b> Min. <b>0</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Officer</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>U. S. Marine Corps</b>		
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Michigan</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		
<b>13. FATHER'S NAME</b> <b>Conrad Kieren</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Marie Gagnon</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>			<b>16. SOCIAL SECURITY NO.</b> <b>406 03 5280</b>		
<b>17. INFORMANT</b> <b>(M) Josephine B. Kieren Same as #2 above</b>			<b>Address</b> <b>Same as #2 above</b>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b> DUE TO (b) <b>Chronic Hypertension</b> DUE TO (c) <b>Branchial carcinoma, 1st stage</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>5 hrs.</b> <b>2 yrs</b> <b>3 1/2 yrs</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)		
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 15, 1961</b> to <b>August 23, 1961</b> that <b>(M)</b> (we) last saw the deceased alive on <b>August 23, 1961</b> , and that death occurred at <b>9:50 PM</b> , from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <b>D. P. Osborne</b>			<b>22b. DATE SIGNED</b> <b>August 24, 1961</b>		
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>D. P. OSBORNE, CAPTAIN, MC, USN</b>			<b>22d. ADDRESS</b> <b>U. S. Naval Hospital, Bethesda, Md.</b>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>28 August 1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b>	
<b>23d. LOCATION</b> (City, town or county) <b>Arlington</b>		<b>23e. (State)</b> <b>Va.</b>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert A. Humphrey</b>	
<b>24. ADDRESS</b> <b>Bethesda, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE AUG 28 '61</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Harris</b>	

MEDICAL CERTIFICATION

pt. of Health prior to burial, cremation, or removal, and in any event, 12 hours after death.

7500

4160

M

692

*Journal of Management Education* 30(6)

UNITED STATES . . .

THE UNIVERSITY OF CHICAGO

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9316

CERTIFICATE OF DEATH

09307

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>four days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> d. STREET ADDRESS <b>3112 McComas Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mrs. Bertha Alice</b> First Middle Last <b>KIRK</b>		4. DATE OF DEATH Month <b>Aug</b> Day <b>19</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 12, 1886</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Randolph County, N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Addison Albred</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Elizabeth Connor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>3213 Green</b>	
17. INFORMANT <b>Mrs. Robert F. Grant</b>		Address <b>Burtonsville, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laber Pneumonia</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <b>Acute Congestive Heart Failure</b> (c) <b>Anterior Sclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b> <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 16, 1961</b> to <b>Aug 19, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 19, 1961</b> , and that death occurred at <b>8:30 am</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert T. Thibadeau</b> M.D.		22b. DATE <b>August 19, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert T. Thibadeau, M.D.</b>		22d. ADDRESS <b>10609 Concord Street, Kens., Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/22/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Colesville Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Colesville, Montgomery, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey, Inc.</b>		25. REC'D BY REGISTRAR <b>AUG 24 '61</b>	
ADDRESS <b>6454 Georgia Avenue Silver Spring, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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CERTIFICATE OF DEATH

1918



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9317

CERTIFICATE OF DEATH

09308

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>District of Columbia</u> h. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
c. LENGTH OF STAY in 1b <u>1 day 14 hrs.</u>				d. STREET ADDRESS <u>1530 Rhode Island Ave. N.E.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Willie Tennings Knight</u>				4. DATE OF DEATH <u>August 17 1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 17, 1896</u> <u>64</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard Force USA - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Willie J. Knight</u>				14. MOTHER'S MAIDEN NAME <u>Susie Belding</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>WWI Army</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>no</u>			
17. INFORMANT <u>Hospital Chert</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>carcinoma of the lung</u> (c), stating the underlying cause last. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>18 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
2Dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>1960</u> to <u>8/16</u> , 19 <u>61</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>8/16</u> , 19 <u>61</u> , and that death occurred at <u>4:55</u> A.M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Hugh W. Iney</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Hugh W. Iney</u>				22d. ADDRESS <u>7105 Riggs Road, Hyattsville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>8/19/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Port Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.A. Harris Co.</u>				25a. REC'D BY REGISTRAR <u>2201-144 SP. 7.10</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	
				DATE <u>AUG 21 '61</u>			

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THE  
LIBRARY OF THE  
CONGRESS  
WASHINGTON, D. C.  
20540



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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9318

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09309

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 4 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE North Carolina		b. COUNTY Jacksonville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		First Michael		Middle Dean		Last Kratzer		3. DATE OF DEATH August 7 1961	
4. NAME OF DECEASED (Type or print) Male		5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-20-61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) North Carolina		9. AGE (in years last birthday) 1 yrs. 18 Months		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME David Harrison Kratzer		14. MOTHER'S MAIDEN NAME Loretta Torrente		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT David H. Kratzer Same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1% (b) DUE TO (c) Congenital heart disease, (coarctation of aorta)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) August 3 1961		20g. (County) August 7 1961		20h. (State) August 7 1961		20i. (City or town) August 7 1961		20j. (County) August 7 1961	
20k. (State) August 7 1961		20l. (City or town) August 7 1961		20m. (County) August 7 1961		20n. (City or town) August 7 1961		20o. (County) August 7 1961	
20p. (State) August 7 1961		20q. (City or town) August 7 1961		20r. (County) August 7 1961		20s. (City or town) August 7 1961		20t. (County) August 7 1961	
20u. (State) August 7 1961		20v. (City or town) August 7 1961		20w. (County) August 7 1961		20x. (City or town) August 7 1961		20y. (County) August 7 1961	
20z. (State) August 7 1961		20aa. (City or town) August 7 1961		20ab. (County) August 7 1961		20ac. (City or town) August 7 1961		20ad. (County) August 7 1961	
20ae. (State) August 7 1961		20af. (City or town) August 7 1961		20ag. (County) August 7 1961		20ah. (City or town) August 7 1961		20ai. (County) August 7 1961	
20aj. (State) August 7 1961		20ak. (City or town) August 7 1961		20al. (County) August 7 1961		20am. (City or town) August 7 1961		20an. (County) August 7 1961	
20ao. (State) August 7 1961		20ap. (City or town) August 7 1961		20aq. (County) August 7 1961		20ar. (City or town) August 7 1961		20as. (County) August 7 1961	
20at. (State) August 7 1961		20au. (City or town) August 7 1961		20av. (County) August 7 1961		20aw. (City or town) August 7 1961		20ax. (County) August 7 1961	
20ay. (State) August 7 1961		20az. (City or town) August 7 1961		20ba. (County) August 7 1961		20bb. (City or town) August 7 1961		20bc. (County) August 7 1961	
20bd. (State) August 7 1961		20be. (City or town) August 7 1961		20bf. (County) August 7 1961		20bg. (City or town) August 7 1961		20bh. (County) August 7 1961	
20bi. (State) August 7 1961		20bj. (City or town) August 7 1961		20bk. (County) August 7 1961		20bl. (City or town) August 7 1961		20bm. (County) August 7 1961	
20bn. (State) August 7 1961		20bo. (City or town) August 7 1961		20bp. (County) August 7 1961		20bq. (City or town) August 7 1961		20br. (County) August 7 1961	
20bs. (State) August 7 1961		20bt. (City or town) August 7 1961		20bu. (County) August 7 1961		20bv. (City or town) August 7 1961		20bw. (County) August 7 1961	
20bx. (State) August 7 1961		20by. (City or town) August 7 1961		20bz. (County) August 7 1961		20ca. (City or town) August 7 1961		20cb. (County) August 7 1961	
20cc. (State) August 7 1961		20cd. (City or town) August 7 1961		20ce. (County) August 7 1961		20cf. (City or town) August 7 1961		20cg. (County) August 7 1961	
20ch. (State) August 7 1961		20ci. (City or town) August 7 1961		20cj. (County) August 7 1961		20ck. (City or town) August 7 1961		20cl. (County) August 7 1961	
20cm. (State) August 7 1961		20cn. (City or town) August 7 1961		20co. (County) August 7 1961		20cp. (City or town) August 7 1961		20cq. (County) August 7 1961	
20cr. (State) August 7 1961		20cs. (City or town) August 7 1961		20ct. (County) August 7 1961		20cu. (City or town) August 7 1961		20cv. (County) August 7 1961	
20cw. (State) August 7 1961		20cx. (City or town) August 7 1961		20cy. (County) August 7 1961		20cz. (City or town) August 7 1961		20da. (County) August 7 1961	
20db. (State) August 7 1961		20dc. (City or town) August 7 1961		20dd. (County) August 7 1961		20de. (City or town) August 7 1961		20df. (County) August 7 1961	
20dg. (State) August 7 1961		20dh. (City or town) August 7 1961		20di. (County) August 7 1961		20dj. (City or town) August 7 1961		20dk. (County) August 7 1961	
20dl. (State) August 7 1961		20dm. (City or town) August 7 1961		20dn. (County) August 7 1961		20do. (City or town) August 7 1961		20dp. (County) August 7 1961	
20dq. (State) August 7 1961		20dr. (City or town) August 7 1961		20ds. (County) August 7 1961		20dt. (City or town) August 7 1961		20du. (County) August 7 1961	
20dv. (State) August 7 1961		20dw. (City or town) August 7 1961		20dx. (County) August 7 1961		20dy. (City or town) August 7 1961		20dz. (County) August 7 1961	
20ea. (State) August 7 1961		20eb. (City or town) August 7 1961		20ec. (County) August 7 1961		20ed. (City or town) August 7 1961		20ee. (County) August 7 1961	
20ef. (State) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961	
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20ef. (State) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961	
20ef. (State) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961	
20ef. (State) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961	
20ef. (State) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961	
20ef. (State) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961	
20ef. (State) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961	
20ef. (State) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961	
20ef. (State) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961	
20ef. (State) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961	
20ef. (State) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961	
20ef. (State) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961	
20ef. (State) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961	
20ef. (State) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961	
20ef. (State) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961	
20ef. (State) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961		20ef. (City or town) August 7 1961		20ef. (County) August 7 1961	
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2312



Deborah (Hart)

U.S. Naval Hospital

Michael

Caroline

Chris

David Harrison Korman

in

North Carolina

Johnston

U.S. Naval Hospital

Robert

Dan

0-0-01

North Carolina

Johnston

David H. Korman, Director of

*Constitution of the*  
*Constitution of the*

*Letter to*

U.S. Naval Hospital

U.S. Naval Hospital

U.S. Naval Hospital, Baltimore, Md.

8-8-81

8-8-81

9319

## CERTIFICATE OF DEATH

Reg. Dist. No. 9310

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>SILVER SPRING 20</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1078 RUATAN ST.</b>				d. STREET ADDRESS <b>1078-RUATAN, ST</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>SIMON KUZMINSKY</b>				4. DATE OF DEATH Month Day Year <b>AUG. 16- 1961</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 1895</b>	
9. AGE (In years last birthday) <b>65 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GROCKR</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>RUSSIA</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>	
13. FATHER'S NAME <b>AKIVA KUZMINSKY</b>				14. MOTHER'S MAIDEN NAME <b>CHAYA</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>578-34-5096</b>			
17. INFORMANT <b>MORTON KIZNER</b>				Address <b>1078 RUATAN ST.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain Tumor</b> 237 X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Uremia.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 12, 1961</b> to <b>Aug 16, 1961</b> , that I last saw the deceased alive on <b>Aug 15, 1961</b> , and that death occurred at <b>10:55 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Morton Altschuler</b> M.D.				ADDRESS (Street, city or town, state) <b>9205 New Hampshire</b> DATE SIGNED <b>8/16/61</b>			
PHYSICIAN'S NAME (Type) <b>Morton Altschuler, M.D. Silver Spring, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>AUGUST 17, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MT. LEBANON CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>HYATTSVILLE MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bernard Dargatzis &amp; Sons</b>				ADDRESS <b>3501-14 ST. NW</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 24 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles E. Hume</b>			

Page 4

The law requires that the death certificate be executed within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

VS A15 (4)

15M 9/58

1918

DATE OF DEATH

DECEASED

11

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

Signature

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

AGE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9320

## CERTIFICATE OF DEATH

09311

<b>1. PLACE OF DEATH</b> e. COUNTY <b>Montgomery</b> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Springfield</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Springfield</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>5512 Pollard Rd.</b>		d. STREET ADDRESS <b>5512 Pollard Rd.</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>ROGER A. LaGUARDIA</b>		<b>4. DATE OF DEATH</b> Month <b>Aug.</b> Day <b>5,</b> Year <b>1961</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>May 22, 1925</b>
<b>9. AGE</b> (In years last birthday) <b>36</b> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <b>2</b> Days <b>13</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Administrative Asst - Hospital</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>New York</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		<b>13. FATHER'S NAME</b> <b>Gari LaGuardia</b>	
<b>14. MOTHER'S MAIDEN NAME</b> <b>Francesca Sciomari</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <b>WW 2</b>	
<b>16. SOCIAL SECURITY NO.</b> <b>577-30-3188</b>		<b>17. INFORMANT</b> <b>Barbara M. LaGuardia-wife-same 2d</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>myocardial infarction</b> DUE TO (b) <b>Coronary Thrombosis</b> DUE TO (c) <b>coronary arteriosclerosis</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 hr</b> <b>2 hrs.</b> <b>Indefinite</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <b>None</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
<b>20c. TIME OF INJURY</b> Hour a.m. <b>19</b> p.m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Feb 2, 1958</b> <b>to</b> <b>8/5/61</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>8/5/61</b> , <b>and that death occurred at</b> <b>Springfield</b> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>Stephen N. Jones MD</b>		<b>22b. DATE SIGNED</b> <b>8/7/61</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>STEPHEN N. JONES</b>		<b>22d. ADDRESS</b> <b>809 Viers Mill Rd., Rockville, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>8/9/61</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington Nat. Cem.</b>	<b>23d. LOCATION</b> (City, town or county) (State) <b>Arlington, Virginia</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert A. Pumphrey</b>		<b>25a. REC'D BY REGISTRAR</b> <b>AUG 9 '61</b>	
<b>ADDRESS</b> <b>Bethesda, Maryland</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>	

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(M)

(I)

New York  
May 1, 1955

Administrative Asst - Hospital

Francisco Solomons

Unit Laguardia

Yes  
100-50-100 Bureau of Investigation - New York

Enclosed for the  
Bureau of Investigation  
are two copies of the  
report of the  
investigation of the  
alleged activities of  
the subject.

Very truly yours,  
STANLEY A. JONES  
Two copies will be  
forwarded to the  
Bureau of Investigation.

Robert A. Humphrey, Bethesda, Maryland  
Washington Field, Com.  
Bureau of Investigation



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9321

## CERTIFICATE OF DEATH

Reg. Dist. No. 09312

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. LENGTH OF STAY IN 1b <b>Since 1937</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6901 Beechwood Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Ers</b> Last <b>Lamb</b>		4. DATE OF DEATH Month <b>August</b> Day <b>7</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 1886 74</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attorney-ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Patent Atty.</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Francis A. Lamb</b>		14. MOTHER'S MAIDEN NAME <b>Peharoh Ewin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Bill Lamb-son-same 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CACHEXIA and Exhaustion</b> <b>153.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA of the Sigmoid</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 Mo</b> <b>5 YRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>FEB 28, 1949</b> to <b>AUG 7, 1961</b> , that I last saw the deceased alive on <b>AUG 6, 1961</b> , and that death occurred at <b>12:30 PM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Horace H. Custis Jr</b>		DATE SIGNED <b>8/7/61</b>	
PHYSICIAN'S NAME (Type) <b>HORACE H. CUSTIS JR</b>		ADDRESS (Street, city or town, state) <b>1852 Columbia Rd. N.W. Washington DC</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>8/7/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>AUG 9 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kline</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2321

Form with multiple lines for text entry, including fields for name, date, and location. The text is mirrored and appears to be bleed-through from the reverse side of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9322

## CERTIFICATE OF DEATH

09313

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San. &amp; Hospital</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1133 Chickasaw Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <u>George Anthony Lambas</u>		<b>4. DATE OF DEATH</b> Last <u>Aug</u> Month <u>29</u> Day <u>1961</u>		<b>5. SEX</b> <u>Male</u>	
<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>9/21/88</u>	
<b>9. AGE</b> (In years last birthday) <u>72</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Restaurant-Owner-retired</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Greece</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>Anthony Lambas</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Anna Vlissidis</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>578001-8345</u>		<b>17. INFORMANT</b> Address <u>Hospital Records</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>332 X</u> IMMEDIATE CAUSE (a) <u>Left Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes mellitus &amp; Arteriosclerotic Heart disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). <u>Diabetes mellitus &amp; Arteriosclerotic Heart disease</u>					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b>		<b>20g. (County)</b>		<b>20h. (State)</b>	
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>December 1957</u> to <u>Aug. 29, 1961</u> , that (I) <u>(M)</u> last saw the deceased alive on <u>Aug. 28, 1961</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <u>Russell B. Arnold</u>		<b>22b. DATE SIGNED</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Russell B. Arnold M.D.</u>	
<b>22d. ADDRESS</b>		<b>22e. MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>			
<u>8801 Cokesville Road,</u>		<u>Silver Spring, Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>burial</u>		<b>23b. DATE THEREOF</b> <u>9/1/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Ft. Lincoln Cemetery</u>	
<b>23d. LOCATION</b> (City, town or county) <u>Prince Georges, Md.</u>		<b>23e. (State)</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The S.H. Hines Co.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>SEP 1 '61</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>	
<b>24c. ADDRESS</b> <u>2901 14th St. N.W.</u>		<b>24d. CITY</b> <u>Washington 9, D.C.</u>			

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Montgomery  
Tenn. and Ark.  
George Washington  
Note in  
Resurrection-Union-Editor  
Anthony Chambers  
Anna Virsides  
Greene  
9/11/88  
1884

W. H. Miller Co. Wheeling, W. Va.  
W. H. Miller Co. Wheeling, W. Va.  
W. H. Miller Co. Wheeling, W. Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9323

## CERTIFICATE OF DEATH

09314

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN b <b>Two years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1602 Dublin Drive</b>		d. STREET ADDRESS <b>1602 Dublin Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RI CHARD JOHN LAVERY</b>		4. DATE OF DEATH Month <b>8</b> Day <b>2</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Oct. 20, 1877</b>	9. AGE (In years last birthday) <b>83 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Attorney</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Claims Dept. Insurance Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Chicago, Illinois</b>	
13. FATHER'S NAME <b>John Lavery</b>		14. MOTHER'S MAIDEN NAME <b>Mary Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Emma G. Lavery</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>10 YEARS</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). <b>NONE - SENILITY</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 1961</b> to <b>8/2</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>April 1961</b> , and that death occurred at <b>2:45 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Henry W. Stout</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/2/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>HENRY W. STOUT</b>		22d. ADDRESS <b>10,011 Georgia Avenue, Silver Spring, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/4/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	
23d. LOCATION (City, town or county) <b>Montgomery County, Maryland</b>		23e. (State) <b>Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey, Inc.</b>		ADDRESS <b>8434 Georgia Avenue</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 7 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur E. Hume</b>					

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Silver Spring

Two Years

Two Years

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1902 Dublin

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Barred Attorney

John Lavery

John Lavery

Mr. John G. Lavery, 1902 Dublin, Ireland

John

1902 Dublin, Ireland

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1902 Dublin, Ireland

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1902 Dublin, Ireland

1902 Dublin, Ireland

1902 Dublin, Ireland

1902 Dublin, Ireland



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificates be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9324

Item 4 Film G293

8/28/61 ink

09315

1. PLACE OF DEATH e. COUNTY <b>Montg,</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Montg,</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg. Rural</b>	
c. LENGTH OF STAY IN 1b <b>5 Weeks</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rest Haven Rest Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John Mills Lawson</b>		4. DATE OF DEATH Month <b>Aug</b> Day <b>18</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 5th 1886</b>
9. AGE (In years last birthday) <b>74 yrs.</b>		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>9</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired. Auster.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lee's Burg. Va.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John W. Lawson</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Mills</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes give year or dates of service) <b>213 16 2968</b>	
17. INFORMANT <b>Grace E. Partin. Rockville. Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO (b) <b>Carcinoma of Pancreas</b> DUE TO (c) <b>Metastasis to bones of Pelvis</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1960</b> , 19 to <b>8/14</b> , 19, that (I) (we) last saw the deceased alive on <b>8/13</b> , 19, and that death occurred at <b>11</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Luciano I. Ledl</b>		22b. DATE SIGNED <b>Aug 16 '61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Luciano I. Ledl</b>		22d. ADDRESS <b>Gaithersburg, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-16-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lake View</b>		23d. LOCATION (City, town or county) (State) <b>Hamilton. Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner. Gaithersburg. Md.</b>		25a. REC'D BY REGISTRAR <b>Aug 16 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

M

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1934

Home,

Galveston, Texas

5 Weeks

Galveston, Texas

Home Haven Hotel

300 N. Henderson Ave.

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Lawson

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Home, Texas.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9325

09316

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY in 1b <b>5 Days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>MARYLAND</b>		f. COUNTY <b>Prince Georges</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		d. STREET ADDRESS <b>500 Greenlawn Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>JAMES WARD LAWYER</b>		4. DATE OF DEATH Month <b>August</b>		Day <b>3</b>		Year <b>1961</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 19 - 1889</b>		9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>71</b>		IF UNDER 24 HRS. Days <b>71</b>		Hours <b>71</b>		Min. <b>71</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Interior Decorator</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Philip H. Lawyer</b>		14. MOTHER'S MAIDEN NAME <b>Delilah Huttie</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Hospital Records</b>		17. INFORMANT <b>Hospital Records</b>		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Longestive heart failure</b> Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic heart disease</b> (c) <b>2 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchitis, acute. Bronchiectasis. Emphysema.</b>														INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b> <b>2 years</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)														20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) <b>Prince Georges County, Md.</b>													
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 1, 1961</b> to <b>Aug 3, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 2, 1961</b> , and that death occurred at <b>12:05 A.M.</b> from the causes and on the date stated above.														22a. SIGNATURE <b>Seruch T. Kimble</b>		22b. DATE SIGNED <b>3 Aug 61</b>		22c. PHYSICIAN'S NAME (Type) <b>Seruch T. Kimble</b>		22d. ADDRESS <b>927 Pershing Dr. Silver Spring, Md.</b>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>8/5/61</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>				23d. LOCATION (City, town or county) <b>Prince Georges County, Md.</b>													
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Vincent</b>				ADDRESS <b>2525 Bladensburg Rd Wash DC</b>				25a. REC'D BY REGISTRAR <b>DATE AUG 8 '61</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>													

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9326

## CERTIFICATE OF DEATH

09317

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural</b> c. LENGTH OF STAY IN 1b <b>3yr. 10mo 619days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Waverly Sanitarium</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westmorland Hills 57</b> d. STREET ADDRESS <b>5314 Carvel Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Nancy</b>		First Middle Last <b>A. Leatherwood</b>		4. DATE OF DEATH Month <b>August</b> Day <b>31</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-18-1872</b>	9. AGE (In years last birthday) <b>88</b> yrs.	IF UNDER 1 YEAR Months <b>8</b> Days <b>18</b> Hours <b>15</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>Henry Albaugh</b>			14. MOTHER'S MAIDEN NAME <b>Mary Longnecker</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT Address <b>Louis P. Allwine, Waverley Sanitarium</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Intestinal hemorrhage, severe</b> 236X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Suspected growth in intestines</b> DUE TO (c) <b>1 yr.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>15 min</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from <b>Jan 1955</b> to <b>31 Aug 61</b> that (I) (we) last saw the deceased alive on <b>28 July 61</b> , and that death occurred at <b>11:25 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Herbert Martyn Jr</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>31 Aug 61</b>			
22c. PHYSICIAN'S NAME (Type) <b>HERBERT MARTYN JR</b>		22d. ADDRESS <b>5029 Bethesda Ave. Bethesda Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>9-6-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>			
23d. LOCATION (City, town or county) <b>Salt Lake City, Utah</b>		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Lawler's Sons, Inc.</b>		ADDRESS <b>1756 Pa. Ave. N.W. Wash. C. D.C.</b>		25a. REC'D BY REGISTRAR <b>SEP 6 '61</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Arnold</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15 mm 2002, specimen 2002-15

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12 p. 2 of 85.



of Captain W. K. Rebell

ЗА АБСЕНТЭА РЛОС ЯЛ ИКТААМ ТЯЖАЭН



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

09318

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>13 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>1555 Fort Dupont St. N. W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Landreville</b> First Middle Last		<b>4. DATE OF DEATH</b> <b>August 13 1961</b> Month Day Year		<b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>Caucasian</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>1-22-98</b> 9. AGE (In years last birthday) <b>63</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Officer</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>U.S. Marine Corp</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Washington, D.C.</b> <b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>		<b>13. FATHER'S NAME</b> <b>Onesime LeDoux</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Ida M. Howe</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> (If yes give year or dates of service) <b>WW II</b>		<b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <b>Bertha T. LeDoux</b> Address <b>Same as #2 above</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Coma</b> (b) <b>Cirrhosis Liver, Laennec's Type</b> (c) <b>581.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 31 1961</b> to <b>August 13 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>August 13 1961</b> , and that death occurred at <b>8:50 PM</b> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>John M. Lewis LCDR, MC USN</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>JOHN M. LEWIS, LCDR MC USN</b>		<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/> <b>August 14, 1961</b> <b>22d. ADDRESS</b> <b>U. S. Naval Hospital, Bethesda, Md.</b>		<b>22b. DATE SIGNED</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>August 17, 1961</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Lee Funeral Home, Inc.</b> <b>4th and Mass, N.E. D. C.</b>		<b>25a. REG. IN REGISTRAR</b> <b>August 16 1961</b> <b>DATE</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hays</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please extend the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9328 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 9 Film G292 8/10/61											
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>				c. LENGTH OF STAY IN 1b <i>1 day</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Woodley Gardens Office Bldg.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
2. USUAL RESIDENCE (Where deceased lived, if different from residence before admission) a. STATE <i>MD</i>				b. COUNTY <i>Montg</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>			
d. STREET ADDRESS <i>9310 Burning Tree Rd</i>				e. DATE OF DEATH Month <i>Aug</i> Day <i>1</i> Year <i>1961</i>				f. DATE OF DEATH Month <i>Aug</i> Day <i>1</i> Year <i>1961</i>			
3. NAME OF DECEASED (Type or print) <i>Thomas Girard Lee</i>		4. SEX <i>male</i>		5. COLOR OR RACE <i>white</i>		6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>5-10-1908</i>	
9. AGE (In years, last birthday) <i>53</i>		10. IF UNDER 1 YEAR Months <i>5</i> Days <i>23</i>		11. IF UNDER 24 HRS. Hours <i>1</i> Min. <i>00</i>		12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Office manager</i>		13. KIND OF BUSINESS OR INDUSTRY <i>Const. Co.</i>		14. BIRTHPLACE (State or foreign country) <i>D.C.</i>	
15. CITIZEN OF WHAT COUNTRY? <i>U.S.C.</i>		16. FATHER'S NAME <i>Walter H. Lee</i>		17. MOTHER'S MAIDEN NAME <i>Sarah W. Washington</i>		18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		19. SOCIAL SECURITY NO. <i>214-36-2777</i>		20. INFORMANT <i>T. Girard Lee, Jr. (SON)</i>	
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X Termination of Brain Stem</i>		IMMEDIATE CAUSE (b) <i>Intra-ventricular cerebral hemorrhage</i>		IMMEDIATE CAUSE (c) <i>Sudden</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>		22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		23. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
24. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		25. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		26. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		27. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		28. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		29. (City or town) (County) (State)	
30. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		31. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		32. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		33. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		34. DATE SIGNED <i>8-2-61</i>		35. ACTUAL SIGNATURE <i>Frank J. Broscham</i>	
36. EXAMINER'S NAME (Type) <i>FRANK J. Broscham</i>		37. ADDRESS <i>Bethesda, Maryland</i>		38. REC'D BY REGISTRAR <i>AUG 7 '61</i>		39. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>		40. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		41. DATE THEREOF <i>8/4/61</i>	
42. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		43. LOCATION (City, town, or country) (State) <i>Rockville, Maryland</i>		44. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>		45. ADDRESS <i>Bethesda, Maryland</i>		46. VS. A15ME 5M 9/60		47. VS. A15ME 5M 9/60	

(M)

James W. Washington

Walter H. Lee

210-30-1717

Robert A. Pughney, Bethesda, Maryland  
Burial 8/4/01  
Parkman Cemetery, Rockville, Maryland

Reg. Dist. No. 09320

## MEDICAL CERTIFICATION

00380

CERTIFICATE OF DEATH

00380



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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9330

## CERTIFICATE OF DEATH

09321

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN b. <b>15 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>South Carolina</b> b. COUNTY <b>✓</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Spartanburg</b> d. STREET ADDRESS <b>1063 Boiling Springs Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Timothy</b> Middle <b>Clark</b> Last <b>Lister</b>		<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>3</b> Year <b>1961</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Caucasian</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>August 11, 1960</b>
<b>9. AGE</b> (In years last birthday) <b>11</b> yrs. <b>11</b> months <b>22</b> days <b>11</b> hours <b>22</b> min.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Child</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Child</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Japan</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>USA</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Robert Marchant Lister</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Evelyn Elizabeth Kimbrell</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Robert M. Lister</b>	
<b>17. INFORMANT</b> <b>Same as #2 above</b>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tetralogy of Fallot</b> DUE TO (b) <b>754.0</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <b>DUE TO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>19</b> o.m. <b>19</b> p.m.	
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> <b>July 19, 1961</b>		<b>20g. (County)</b> <b>August 3, 1961</b>	
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 19, 1961</b> to <b>August 3, 1961</b> , that (a) (we) last saw the deceased alive on <b>August 3, 1961</b> , and that death occurred <b>12:07 PM</b> from the causes and on the date stated above.		<b>22a. SIGNATURE</b> <b>R.P. DOBBIE, JR. CDR MC USN</b>	
<b>22b. DATE SIGNED</b> <b>August 3, 1961</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>R.P. DOBBIE, JR. CDR MC USN</b>	
<b>22d. ADDRESS</b> <b>U. S. Naval Hospital, Bethesda, Md.</b>		<b>22e. ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial - Shipment</b>		<b>23b. DATE THEREOF</b> <b>4 August 1961</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Spartanburg</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>S. C.</b>	
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <b>Rinaldi's Funeral Home, Washington, D. C.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE AUG 7 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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[illegible]

2003

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9331

## CERTIFICATE OF DEATH

04322

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b. <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>48 Bethesda</u> d. STREET ADDRESS <u>17809 Tilbury St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mercedes L. Little</u>		<b>4. DATE OF DEATH</b> Last <u>Little</u> Month <u>August</u> Day <u>7</u> Year <u>1961</u>		<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>April 24 1878</u>		<b>9. AGE</b> (If years, last birthday) <u>83</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>PARIS, FRANCE</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		
<b>13. FATHER'S NAME</b> <u>Joseph P. SAGRARIO</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Josephine B. Ilean</u>								
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>218-30-3403</u> (MARGUERITE HOGSJAARD)				<b>17. INFORMANT</b> <u>Sister</u> Address <u>SAME AS ABOVE</u>						
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Confluent Arteriovenous aneurysm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Cerebrovascular Accident</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>  </u>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>5 days</u> <u>5 days</u>		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>														
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>  </u> p.m. <u>  </u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>		<b>20f. (City or town)</b> (County) (State) <u>  </u>						
<b>21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1, 1961</u>, to <u>Aug 7, 1961</u>, that (I) (we) last saw the deceased alive on <u>Aug 7, 1961</u>, and that death occurred at <u>1:45 P.M.</u> from the causes and on the date stated above.</b>														
<b>22a. SIGNATURE</b> <u>Dr. Joseph Kenrick</u>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <u>Aug 7, 1961</u>			<b>22b. DATE SIGNED</b>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Dr. JOSEPH KENRICK</u>						<b>22d. ADDRESS</b> <u>6450 Wisconsin Ave, Bethesda, Md.</u>								
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>8-10-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rockville Cemetery</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>Rockville, Maryland</u>				
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <u>ROBERT A. PUMPHREY</u>						<b>ADDRESS</b> <u>Bethesda, Md.</u>			<b>25a. REC'D BY REGISTRAR</b> DATE <u>AUG 14 '61</u>			<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Frank</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 of this certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10722

10722



Confidential  
Unrecorded

CONFIDENTIAL  
UNRECORDED  
CONFIDENTIAL  
UNRECORDED  
CONFIDENTIAL  
UNRECORDED

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

22a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

8/19/61

22c. NAME OF CEMETERY OR CREMATORY

Center County Memorial Park

22d. LOCATION (City, town, or country) (State)

Center County, Pennsylvania

23. FUNERAL DIRECTOR

Raymond R. Zisk 8434 Georgia Avenue  
Warner E. Pumphrey Inc. Silver Spring, Maryland

24a. REC'D BY REGISTRAR

AUG 17 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Kneass

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN 1b

DOA

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington San & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Pennsylvania

b. COUNTY

Centre

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

XXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXXXXXXXXXX

BOALSBURG

d. STREET ADDRESS

KENNARD ROAD Rt 1 Box 457-5

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

Jesse Elmer Livingston

4. DATE OF DEATH

8 15 1961

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

8-3-09

9. AGE (In years last birthday)

52 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

University Professor - Head of Dept. Nebraska

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Nebraska

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Cyrus L. Livingston

14. MOTHER'S MAIDEN NAME

ELIZABETH Spangler -

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

No

16. SOCIAL SECURITY NO. (If yes, give number or dates of service)

506-264578

17. INFORMANT

Mr. William D. Bell - Mrs. Zina May Livingston - wife

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

DUE TO

Coronary occlusion

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.

Month, Day, Year

19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Frank J. Broschert

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S NAME (Type)

FRANK J. Broschert

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

8-15-61





9333

## CERTIFICATE OF DEATH

Reg. Dist. No.

09324

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>703 Gail Avenue</b>		d. STREET ADDRESS <b>703 Gail Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>LAURA (NM) LIVINGSTON</b>		4. DATE OF DEATH <b>August 17, 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 16, 1877</b>
9. AGE (In years lost birthday) <b>84 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>James D. Berry</b>		14. MOTHER'S MAIDEN NAME <b>Mary Duncan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b>	
INFORMANT <b>Maud Livingston-Item # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis, generalized</b> DUE TO (c) <b>?</b> INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>? years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec. 17, 1955</b> to <b>Aug. 17, 1961</b> , that I last saw the deceased alive on <b>Aug. 10, 1961</b> , and that death occurred at <b>8:50 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>809 Veirs Mill Rd Rockville, Md.</b> DATE SIGNED <b>8/17/61</b>			
ACTUAL SIGNATURE <b>G. Bowditch Hunter, Jr.</b> M.D.		PHYSICIAN'S NAME (Type) <b>G. Bowditch Hunter, Jr. Rockville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit</b>	22b. DATE THEREOF <b>8/18/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hickory Point</b>	22d. LOCATION (City, town, or county) (State) <b>Iberia, Missouri</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler Funeral Home-1331 E. Montgomery Ave Rockville, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 21 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 4 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
9334 09325											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>Years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>220 Park Ave</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>15 Takoma Park</b> d. STREET ADDRESS <b>220 Park Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Jessie F. Lockwood</b>						4. DATE OF DEATH <b>Aug. 26 19 61</b>					
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/26/1871</b>		9. AGE (In years birthday) <b>90 yrs.</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Not Available</b>						14. MOTHER'S MAIDEN NAME <b>Not Available</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>(If yes give war or dates of service)</b>		17. INFORMANT <b>6323 McComb St., N.W. Olivia McMahon Washington, D.C.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>420.1</b> <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>sudden</b>										INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Frank J. Broschart</b> EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>8/26/61</b> DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <b>Aug. 28, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		22d. LOCATION (City, town, or country) <b>Washington, D.C.</b>			
23. FUNERAL DIRECTOR <b>J. Arthur Walters, 254 Carroll Ave NW</b>						24a. REC'D BY REGISTRAR <b>AUG 29 '61</b> DATE 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					

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Not Available

Continued on next page

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
9335  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09326

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
c. LENGTH OF STAY IN 1b <b>16 days</b>		d. STREET ADDRESS <b>806 1/2 Parkwood Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Tammie</b> Middle <b>Lynn</b> Last <b>LOUIERE</b>		4. DATE OF DEATH Month <b>August</b> Day <b>2</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-16-61</b>
9. AGE (In years last birthday) <b>17</b> yrs.		IF UNDER 1 YEAR Months <b>17</b> Days <b>17</b> Hours <b>17</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Leo Paul Louviere</b>		14. MOTHER'S MAIDEN NAME <b>Dianna Lou Mayard</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Leo Paul Louviere Same as # 2 above</b>	
17. INFORMANT <b>Leo Paul Louviere Same as # 2 above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>meningitis</b> DUE TO <b>75 IX</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>meningo myelocoele</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>18 hours</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 17, 19 61</b> to <b>August 2, 19 61</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>August 2, 19 61</b> , and that death occurred at <b>7:45 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert V. Rack</b>		22b. DATE SIGNED <b>August 2, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT V. RACK, LT MC USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial - Shipment</b>		23b. DATE THEREOF <b>8-3-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Broussard Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>New Iberia Louisiana</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers</b>		25a. REC'D BY REGISTRAR <b>AUG 4 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>		25c. ADDRESS <b>31st and M St. N. W. Washington, D. C.</b>	

VR A15 (4)  
15M 9/60



Montgomery

Virginia

Bochard (Mural) 10 days

Memphis

U. S. Naval Hospital

1000 Parkway Ave.

Female

Male

ROUTINE

August 2

21

Female Caucasian

7-1-01

21

Infant

Virginia

21

100 Paul Towhite

Diana Towhite

100 Paul Towhite Same as 2 above

21

*Handwritten notes:*  
Mental  
Mental  
Mental

August 2

7:47

July 17

August 2

21

August 2, 1901

U. S. Naval Hospital, Bethesda, Md.

August 2, 1901

100 Paul Towhite

100 Paul Towhite

100 Paul Towhite

100 Paul Towhite



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9336

## CERTIFICATE OF DEATH

Reg. Dist. No. 09327

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Florida</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Orlando</u>		4. STREET ADDRESS <u>Route #2, Box 488 (Maitland)</u>	
d. NAME OF HOSPITAL (If within hospital, give street address) OR INSTITUTION <u>12126 Viers Mill Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LENORE</u> Middle <u>P.</u> Last <u>LUSH</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>15</u> Year <u>1961</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 5, 1889</u>	
9. AGE (In years lost birthday) yrs. <u>72</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>		11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Rosepe M. Harlan</u>				14. MOTHER'S MAIDEN NAME <u>Etta Blanche Brighton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Stephen L. Lush, 12126 Viers Mill Rd. Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of breast</u> DUE TO <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cancer in axillary glands; also in r. femur (?)</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>  </u> o. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>61</u> , to <u>Aug 15</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>aug 14</u> , 19 <u>61</u> , and that death occurred at <u>3:30 p.m.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John N. Andrews</u>				ADDRESS (Street, city or town, state) <u>9601 Colesville Rd</u> DATE SIGNED <u>8-15-61</u>			
PHYSICIAN'S NAME (Type) <u>John N. Andrews</u>				Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 17, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. William Walters, 254 Carroll St NW, DC</u>				24. REC'D BY REGISTRAR DATE <u>AUG 17 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. F...</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John A. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1941</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. DISEASE OR INJURY <i>Coronary Artery Disease</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		11. SIGNATURE OF WITNESSES <i>John A. Smith, Jr.</i> <i>John A. Smith, Sr.</i>		12. SIGNATURE OF REGISTRAR <i>John A. Smith</i>	
13. SIGNATURE OF DECEASED <i>John A. Smith</i>		14. SIGNATURE OF NEXT OF KIN <i>John A. Smith, Jr.</i>		15. SIGNATURE OF BURIAL OFFICER <i>John A. Smith</i>	
16. SIGNATURE OF CHURCH OFFICER <i>John A. Smith</i>		17. SIGNATURE OF MINISTER <i>John A. Smith</i>		18. SIGNATURE OF FUNERAL HOME <i>John A. Smith</i>	
19. SIGNATURE OF CEMETERY <i>John A. Smith</i>		20. SIGNATURE OF INTERVIEWER <i>John A. Smith</i>		21. SIGNATURE OF REPORTER <i>John A. Smith</i>	
22. SIGNATURE OF CORONER <i>John A. Smith</i>		23. SIGNATURE OF JURY <i>John A. Smith</i>		24. SIGNATURE OF JUDGE <i>John A. Smith</i>	
25. SIGNATURE OF DISTRICT ATTORNEY <i>John A. Smith</i>		26. SIGNATURE OF COUNTY CLERK <i>John A. Smith</i>		27. SIGNATURE OF STATE CLERK <i>John A. Smith</i>	
28. SIGNATURE OF SECRETARY <i>John A. Smith</i>		29. SIGNATURE OF ASSISTANT SECRETARY <i>John A. Smith</i>		30. SIGNATURE OF CHIEF CLERK <i>John A. Smith</i>	
31. SIGNATURE OF DEPUTY CLERK <i>John A. Smith</i>		32. SIGNATURE OF RECORDS CLERK <i>John A. Smith</i>		33. SIGNATURE OF INDEXING CLERK <i>John A. Smith</i>	
34. SIGNATURE OF FILE CLERK <i>John A. Smith</i>		35. SIGNATURE OF DISTRIBUTION CLERK <i>John A. Smith</i>		36. SIGNATURE OF ARCHIVING CLERK <i>John A. Smith</i>	
37. SIGNATURE OF PRESERVATION CLERK <i>John A. Smith</i>		38. SIGNATURE OF REPRODUCTION CLERK <i>John A. Smith</i>		39. SIGNATURE OF RELEASE CLERK <i>John A. Smith</i>	
40. SIGNATURE OF OTHER CLERK <i>John A. Smith</i>		41. SIGNATURE OF OTHER CLERK <i>John A. Smith</i>		42. SIGNATURE OF OTHER CLERK <i>John A. Smith</i>	

MEDICAL CERTIFICATION

VR A15 (4)  
15M 9/60



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9338

09329

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>11 yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4202 Dahill Rd.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>4202 Dahill Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Clarence Hamilton MacDougal</b>		4. DATE OF DEATH Month <b>AUG.</b> Day <b>26</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 28, 1888</b>
9. AGE (In years and birth day) <b>73</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>26</b>	IF UNDER 24 HRS. Hours <b>11</b> Min. <b>15</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Tennessee</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. MOTHER'S MAIDEN NAME <b>Annetta Russ</b>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		15. SOCIAL SECURITY NO. <b>408-07-6210</b>	
16. INFORMANT <b>Mrs. Edith G. MacDougal</b>		Address <b>same</b> (wife)	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchiogenic Cancer</b> DUE TO (b) <b>Metastases to Bones</b> DUE TO (c) <b>162.1</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b> <b>2 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour e.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 10, 1961</b> to <b>Aug 26, 1961</b> that (I) (we) last saw the deceased alive on <b>Aug 26, 1961</b> and that death occurred at <b>7:41 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>John J. Curry</b>		22b. DATE SIGNED <b>8/26/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>John J. Curry</b>		22d. ADDRESS <b>10,620 Georgia Ave., Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 28, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Montgomery County, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey, Inc.</b>		25a. REC'D BY REGISTRAR <b>AUG 29 '61</b>	
ADDRESS <b>Silver Spring, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>C. L. S. Hines</b>	

MEDICAL CERTIFICATION

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

9339

09330

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>Maryland</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> <b>3518 Nimitz Road</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>				c. LENGTH OF STAY IN 1b <b>14 YEARS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3518 NIMITZ ROAD</b>				d. STREET ADDRESS <b>3518 Nimitz Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Franklin</b> Middle <b>BONAVENTURE</b> Last <b>Mades</b>				4. DATE OF DEATH Month <b>August</b> Day <b>16</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1918 29, November</b>	
9. AGE (In years lost birthday) <b>42</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>I. B.M. Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Franklin D. Mades</b>				14. MOTHER'S MAIDEN NAME <b>Sarah G. Ray</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>Yes WW2</b>		16. SOCIAL SECURITY NO. <b>577-24-2736</b>		17. INFORMANT <b>Mrs. Mary E. Mades</b> <b>3518 Nimitz Road Kensington, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anoxia</b> DUE TO <b>442X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute congestive heart failure</b> DUE TO (c) <b>Hypertensive cardiovascular renal disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>20 minutes</b> <b>4 hours</b> <b>3 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus; hepatic cirrhosis; ethanolism</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7/25</b> 19 <b>60</b> to <b>8/10</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>7/25</b> 19 <b>61</b> , and that death occurred at <b>4:11</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Joseph D. Connor</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Aug. 16, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Joseph D. Connor, M.D.</b>				22d. ADDRESS <b>9420 Old Georgetown Road, Bethesda</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/19/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Prince Georges County, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey, Inc.</b>				25a. RECORD BY REGISTRAR <b>AUG 21 61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanks</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9340

09331

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>18 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>1819 Lamont Street, N. W.</u> d. STREET ADDRESS <u>478-3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Emilia Antonia</u> <u>Maresta</u>				<b>4. DATE OF DEATH</b> <u>August 21</u> <u>19 61</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>Caucasian</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>4-26-16</u>	
<b>9. AGE</b> (In years last birthday) <u>45</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Argentina</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>Argentina</u>		<b>13. FATHER'S NAME</b> <u>Pedro Nataloni</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Gilda Gervont</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>  </u>		<b>17. INFORMANT</b> <u>(H) Antonio Maresta</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Metastases</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Carcinoma of Breast</u> (c) <u>  </u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>		<b>20f. (City or town)</b> (County) (State) <u>  </u>	
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>August 3</u> <u>19 61</u> to <u>August 21</u> <u>19 61</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>August 21</u> <u>19 61</u> , and that death occurred at <u>8:20 AM</u> , from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>W. F. Warrender</u> M.D.				<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input checked="" type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>August 21, 1961</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>W. F. WARRENDER, LT MC USN</u>				<b>22d. ADDRESS</b> <u>U. S. Naval Hospital, Bethesda, Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>22 August 1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Olivet Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Washington, D. C.</u>	
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <u>S. H. HINES</u> ADDRESS <u>2901 14th St. N.W. Washington, D. C.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>Aug 24 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificates be executed within 24 hours after death. They may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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U. S. Navy Hospital  
Washington, D. C.  
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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

9341

09332

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN lb <u>5 1/2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>1 5803 Melrose Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>John</u> Middle <u>H</u> Last <u>MARTYN</u>				<b>4. DATE OF DEATH</b> Month <u>August</u> Day <u>10</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4 1887</u>		9. AGE (In years lost birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NAVY YARD</u>		11. BIRTHPLACE (State or foreign country) <u>Washington DC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Martyn</u>				14. MOTHER'S MAIDEN NAME <u>Jane Minnis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Florence Martyn</u> wife - same as above Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Gastric Contents</u> DUE TO <u>560.9</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Intestinal obstruction</u> DUE TO <u>36h</u> (c) <u>bilateral inguinal hernia</u> <u>?</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> 19 <u>61</u> , to <u>Aug</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8-10</u> 19 <u>61</u> , and that death occurred at <u>6:55 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Philip R. James</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/10/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Philip R. James</u>				22d. ADDRESS <u>Washington Clinic, Wash. D. C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/14/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>AUG 16 61</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

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CERTIFICATE OF DATA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09333

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in 1b <u>10 YRS.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>2200 Evans Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John V. McCarthy</u>		4. DATE OF DEATH Month Day Year <u>Aug 25 19 61</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 28, 1912</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sale Representative</u>	11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John W. McCarthy</u>	
14. MOTHER'S MAIDEN NAME <u>Bridget T. Reed</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>579-20-1709</u>		17. INFORMANT <u>Mrs. Jean McCarthy</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute left congestive Heart Failure</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronary Thrombosis</u> (c) <u>Hypertensive Cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 Hours</u> <u>5 weeks</u> <u>3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I(a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/21</u> , 19 <u>61</u> , to <u>8/25</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8/25</u> , 19 <u>61</u> , and that death occurred <u>2200M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Henry W. Stout M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>H. W. STOUT MD</u>		22d. ADDRESS <u>10011 GEORGIA AVE SILVER SPRING MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8-28-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GATE-OF-HEAVEN</u>	23d. LOCATION (City, town or county) (State) <u>MONTGOMERY COUNTY, MD.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis J. Collins</u>		25a. RECEIVED BY REGISTRAR <u>Aug 29 61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur J. Hume</u>		25c. REGISTRAR'S SIGNATURE	

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BRIDGES, J. REED

8-22-31 Gate 1, Hellen Minnesota, Minn.  
James J. Galt - 20101 of J. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The physician may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9343

## CERTIFICATE OF DEATH

09334

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY in 1b <b>29 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Colonial Beach</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>524 Lafayette St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Earl Edward McCartney</b>		4. DATE OF DEATH Month <b>August</b> Day <b>11</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-12-89</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b>	11. IF UNDER 24 HRS. Hours <b>1</b> Min. <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Armed Forces</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank McCartney</b>		14. MOTHER'S MAIDEN NAME <b>Thurza M. Treadway</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give number and dates of service) <b>WW II</b>	
17. INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 13</b> , 19 <b>61</b> to <b>August 11</b> , 19 <b>61</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>August 11</b> , 19 <b>61</b> , and that death occurred at <b>2:50 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Paul G. Linaweaver</b>		22b. DATE SIGNED <b>August 11, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>PAUL G. Linaweaver, LCDR MC USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>August 14, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Arlington Va</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Nash and Slaw Funeral Home, Colonial Beach, Va.</b>		25a. REGD BY REGISTRAR <b>AUG 16 61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hays</b>		DATE	

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*Warrant of Fugitive*

*Warrant of Fugitive*  
JAMES M. HENNESSY, born 1901, U.S. Naval Hospital, Baltimore, Md.  
JAMES M. HENNESSY, born 1901, U.S. Naval Hospital, Baltimore, Md.  
JAMES M. HENNESSY, born 1901, U.S. Naval Hospital, Baltimore, Md.

James M. Hennessy, Colonial Bench, Va.  
James M. Hennessy, Colonial Bench, Va.  
James M. Hennessy, Colonial Bench, Va.

TO HOSPITAL OR A FUNDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
9344														
09335														
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>15 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>207 Sycamore Court</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Cynthia Ann McCoy</b>					4. DATE OF DEATH Month <b>August</b> Day <b>22</b> Year <b>1961</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-25-61</b>		9. AGE (In years last birthday) yrs. <b>58</b>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Lonnie Joe McCoy</b>					14. MOTHER'S MAIDEN NAME <b>Patsy Ruth Oliver</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>					16. SOCIAL SECURITY NO.					17. INFORMANT <b>Lonnie Joe McCoy Same as # 2 above</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>754.5</b> IMMEDIATE CAUSE (a) <b>Total anomalous pulmonary venous drainage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congenital heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>August 7, 1961</b> to <b>August 22, 1961</b> , that <del>it</del> (we) last saw the deceased alive on <b>August 22, 1961</b> , and that death occurred <b>10:55 AM</b> , from the causes and on the date stated above.														
22a. SIGNATURE <b>J. E. McClenathan</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>J. E. McClenathan, CDR MC USN</b>					22b. DATE SIGNED <b>August 22, 1961</b> 22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial- shipment</b>			23b. DATE THEREOF <b>23 August 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beulah Church Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Albertville Ala.</b>						
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b> ADDRESS <b>1331 Eastmont, Rockville, Md.</b>					25a. REC'D BY REGISTRAR DATE <b>AUG 24 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

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U. S. Naval Hospital

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U. S. Naval Hospital

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San Francisco



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. It should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9345 CERTIFICATE OF DEATH 09336

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>24 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>North Carolina</b> b. COUNTY <b>Broadway</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Route # 1</b> d. STREET ADDRESS <b>Route # 1</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Luvarta (None) McDougald</b>				4. DATE OF DEATH Month Day Year <b>August 7 19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 1, 1928</b>	
9. AGE (In years last birthday) <b>33 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Adolph Amerson</b>				14. MOTHER'S MAIDEN NAME <b>Odessett Strange</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unascertainable</b>			
17. INFORMANT <b>The Medical Record</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Choriocarcinoma with metastases to lung, liver, gastrointestinal tract, pancreas, skin &amp; muscle</b> DUE TO (b) <b>Gastrointestinal bleeding secondary to metastases</b> DUE TO (c) <b>Bloody pericardial effusion</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Thyrotoxicosis by clinical history</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <b>9 months</b> <b>6 months</b> <b>Unknown</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 14, 19 61</b> to <b>August 7, 19 61</b> that (I) (we) last saw the deceased alive on <b>August 7, 19 61</b> and that death occurred at <b>8:55 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>M. A. Kirschner</b> M.D.				22b. DATE SIGNED <b>8/9/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>M. A. KIRSCHNER, M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>8-10-61</b>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State) <b>Broadway NC</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Grazier's Funeral Home</b>				ADDRESS <b>389-R. SW</b>		25a. REC'D BY REGISTRAR <b>AUG 14 '61</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur J. F...</b>	

The Clinical Center, National  
Institute of Health, Bethesda, Md.

M. A. HINGSHIRE, M.D.

July 11, 1955

August 7, 1955

Unknown

bloody peritoneal effusion

6 months

Central testicular bleeding secondary to metastases

9 months

gastrointestinal tract, pancreas, skin & nodes  
thrombocytopenia with metastases to lung, liver,

Unresectable The Clinical Center, Bethesda, Md.

Medical Record  
Diagnosis

7.3.55

None

hemorrhagic

None

female

12

July 1, 1955

(None)

leucocytes

7

August 1

The Clinical Center, Bethesda, Md.

History

24 days

leucocytes

North Carolina

leucocytes

11

2343

2338

1  
M  
050  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9346

09337

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>35 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>New York</b> b. COUNTY <b>Sherrill</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>434 Kinsley Street</b> d. STREET ADDRESS <b>67x-3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>Patricia Ann McQuade</b>		4. DATE OF DEATH Month <b>August</b> Day <b>10</b> Year <b>1961</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 11, 1951</b>		9. AGE (In years last birthday) <b>10</b> yrs.		IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>				11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Leonard L. McQuade</b>				14. MOTHER'S MAIDEN NAME <b>Janette Crandell</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMATION <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>5 87.3</b> DUE TO <b>Cystic Fibrosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>10 years</b>												INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>10 years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) <b>July 6, 1961 to August 10, 1961</b> <b>3:02AM</b>							
21. I certify that (I) (this hospital) attended the deceased from <b>July 6, 1961</b> to <b>August 10, 1961</b> , that (I) (we) last saw the deceased alive on <b>August 10, 1961</b> , and that death occurred at <b>3:02AM</b> from the causes and on the date stated above.																			
22a. SIGNATURE <b>Gerald F. Powell</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>GERALD F. POWELL, MD</b>								22b. DATE <b>8/10/61</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-transit</b>				23b. DATE THEREOF <b>8/11/1961</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Valley View,</b>				23d. LOCATION (City, town or county) (State) <b>Oneida New York</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>								ADDRESS <b>Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>AUG 14 '61</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

VR A15 (4)  
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be retained by the hospital or attending physician. Page 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH e. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3307 Oberon Street</b>				d. STREET ADDRESS <b>3307 Oberon Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Jean Gould Menefee</b>				4. DATE OF DEATH Month <b>August</b> Day <b>3</b> Year <b>19 61</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/28/64</b>		9. AGE (In years last birthday) <b>96</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>5</b> IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John R. Gould</b>						14. MOTHER'S MAIDEN NAME <b>Amelia Mege</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Jean Sartwell-daughter-same 2d</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>44-2X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>arteriosclerotic-renal disease</b> (a), stating the underlying cause last. (c) <b>arterio sclerosis generalized</b>										INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>years</b> <b>"</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>March, 1961</b> , to <b>August 3, 1961</b> , that (I) (we) last saw the deceased alive on <b>August 1, 1961</b> , and that death occurred at <b>5:29 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Alfred S. Norton</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Alfred S. Norton, M.D.</b>						22d. ADDRESS <b>4711 Highland Ave., Bethesda 14, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>8/5/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Pk. Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>						ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 8 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

(M)

1933

1933

Montgomery

Maryland

Montgomery

1933

1933

1207 Oberon Street

1207 Oberon Street

1933

1933

1933

1933

1933

Female

Female

Female

Housewife

Housewife

Housewife

John A. Davis

John A. Davis

John A. Davis

John A. Davis

John A. Davis

(I)

Robert A. Thompson

Robert A. Thompson

Robert A. Thompson

Robert A. Thompson

Robert A. Thompson

Robert A. Thompson



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
9348  
CERTIFICATE OF DEATH  
09339

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>seven years</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>303 Ladson Road</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring,</b> d. STREET ADDRESS <b>303 Ladson Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Louis Edwin Metcalf</b>		4. DATE OF DEATH Month <b>August</b> Day <b>8</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 13, 1905</b>
9. AGE (In years lost birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR Months <b>55</b> Days <b>55</b> Hours <b>55</b> Min. <b>55</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cafe/teria Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Food Services</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank John son</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Clabaugh</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-03-8683</b>	
17. INFORMANT <b>Mrs. Elizabeth P. Metcalf</b>		Address <b>303 Ladson Road Silver Spring, Maryland</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary Insufficiency</b> DUE TO <b>420.0</b> Circulations, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic heart disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b> <b>SEVERAL YES,</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 1959</b> to <b>Aug 8, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 1, 1961</b> , and that death occurred at <b>1:00 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>M.F. OTTMAN</b>		22b. DATE SIGNED <b>8/9/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>M.F. OTTMAN</b>		22d. ADDRESS <b>11800 Ga Ave</b>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE THEREOF <b>AUG. 9, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>TO GEORGE WASHINGTON MEDICAL SCHOOL, WASHINGTON, D.C. FOR MEDICAL RESEARCH.</b>	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b>		25a. REC'D. BY REGISTRAR <b>AUG 16 '61</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>

100



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

9349

09340

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oakhaven Convalescent Home</u>				d. STREET ADDRESS <u>1743 Irving Street, N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>W.</u> Last <u>Meyer</u>				4. DATE OF DEATH Month <u>August</u> Day <u>22</u> Year <u>1961</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 9, 1912</u>		9. AGE (In years lost birthday) <u>88</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Wilhelm Timm</u>				14. MOTHER'S MAIDEN NAME <u>Johanna Bach</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Wash. D.C.</u> <u>William J. Meyer, 3621 S St. N.W.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bowel Obstruction</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1959</u> to <u>Aug 22, 1961</u> , that (I) (we) lost saw the deceased alive on <u>Aug 21, 1961</u> , and that death occurred at <u>1:35 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>James H. Whitehead MD</u>				22b. DATE SIGNED <u>8-22-61</u>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-24-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gawlinski</u> ADDRESS <u>1756 Pa. Ave. NW</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 25 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Krause</u>	

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CERTIFICATE OF DEATH

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*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 2 and 3 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>68 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21</b> d. STREET ADDRESS <b>320 Popular Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Melvin Alexander Michaelkiewicz</b>		4. DATE OF DEATH Month <b>August</b> Day <b>7</b> Year <b>19 61</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-1-26</b>	
9. AGE (In years last birthday) <b>34</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Armed Forces</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Michaelkiewicz</b>		14. MOTHER'S MAIDEN NAME <b>Eve Patro</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW II 214-20-0168</b>	
17. INFORMANT <b>Ruth Michaelkiewicz</b>		Address <b>Same as #2 above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>diffuse, metastatic neuroblastoma</b> DUE TO (b) <b>neuroblastoma 10 in Rt. sciatic nerve</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>xxx</b> (this hospital) attended the deceased from <b>May 30</b> , 19 <b>61</b> , to <b>August 7</b> , 19 <b>61</b> , that <b>it</b> (we) last saw the deceased alive on <b>August 7</b> , 19 <b>61</b> , and that death occurred at <b>9:25 AM</b> , from the causes and on the date stated above.		22b. DATE SIGNED <b>August 7, 1961</b>	
22a. SIGNATURE <b>B H Rice</b> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>B. H. RICE, LT MC USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>August 11, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc.</b>		ADDRESS <b>St. Paul and Preston St. Baltimore, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>AUG 10 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	



0330

0330

Belmont (Hunt)

U. S. Naval Hospital

Belmont

U. S. Naval Hospital

Belmont

U. S. Naval Hospital

Belmont



U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completed and signed by the funeral director. After this certificate has been signed by the attending physician and completed and signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
9351 CERTIFICATE OF DEATH 09342									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>5 hours 55 min.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>304 Southwest Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Sadie</u>		First <u>Lelia</u>		Middle <u>Milam</u>		Last		4. DATE OF DEATH <u>August 28, 1961</u> Month <u>August</u> Day <u>28</u> Year <u>1961</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 29, 1881</u> yrs. <u>80</u>		9. AGE (In years last birthday) <u>80</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Mississippi</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Archer Tatum</u>				14. MOTHER'S MAIDEN NAME <u>Mollie Tribble</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>Washington Sanitarium &amp; Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 332X DUE TO (b) <u>Cerebral thrombosis with left hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>4 wks</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1961</u> to <u>August 28, 1961</u> , that (I) (we) last saw the deceased alive on <u>August 28, 1961</u> , and that death occurred at <u>10:28 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Bennet A. Porter, Jr.</u>				M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Aug. 28, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr., M.D.</u>				22d. ADDRESS <u>9301 Colesville Rd., Silver Spring Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>SHIP R.R.</u>		23b. DATE THEREOF <u>8-29-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PEA RIDGE CEMETERY</u>		23d. LOCATION (City, town or county) <u>GRENADA</u>		(State) <u>MISS</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Chambers, 1400 Chapin St., N. W.</u>				ADDRESS <u>Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>AUG 30 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Klaus</u>	

(M)

(I)

1881

Montgomery

Tarver Park

800 E

Female white

Housewife

Archer Tatum

No

X

Wed 29, 1881 80

William

John

August 28, 81

Willie Triple

Mississippi

U.S.A.

Washington Sanatorium Hospital Record

Montgomery

Greenwood Silver Spring

Washington Sanatorium Hospital

304 Southwest Drive

## CERTIFICATE OF DEATH

Reg. Dist. No.

09343

9352

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville 32</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4503 Renn Street</b>		d. STREET ADDRESS <b>4503 Renn Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ethel May Miller</b>		4. DATE OF DEATH Month Day Year <b>August 19, 1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/20/89</b>
9. AGE (In years lost birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Schlosser</b>		14. MOTHER'S MAIDEN NAME <b>Georgiana Avery</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Norman Harry Miller</b>		Address <b>same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) <b>9 weeks</b> <b>years</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 20, 1961</b> to <b>August 19, 1961</b> , that I last saw the deceased alive on <b>Aug 19, 1961</b> , and that death occurred at <b>8 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John J. Avery</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>10620 Georgia Ave SE, Silver Spring, Md 8/19/61</b>	
PHYSICIAN'S NAME (Type) <b>John J. Avery</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>8/23/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 22 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician or other person who attended the deceased must be present at the time of signing. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1888		BALTIMORE		MD		MD		USA	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
JAN 15 1933		BALTIMORE		MD		MD		USA		JAN 15 1933		BALTIMORE		MD		MD	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED		DIVORCED	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED		MARRIED	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
JAN 15 1933		BALTIMORE		MD		MD		USA		JAN 15 1933		BALTIMORE		MD		MD	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED		DIVORCED	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED		MARRIED	

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9353

## CERTIFICATE OF DEATH

09344

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>2 yrs. 6 mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>8500 Flower Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>Janet</u> First <u>None</u> Middle <u>Miller</u> Last		<b>4. DATE OF DEATH</b> <u>August 10</u> Month <u>1961</u> Day Year		<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>6-28-75</u>		<b>9. AGE</b> (In years last birthday) <u>86</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>New York</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Samuel Miller</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah Colvin</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> <u>Washington San &amp; Hosp Records</u> Address					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> DUE TO (b) <u>Auricular Fibrillation</u> DUE TO (c) <u>Subacute Nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> <u>4 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Hour a.m. p.m.		Month, Day, Year <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		(County) (State)			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>1956</u> , 19 <u>61</u> , to <u>Aug 10</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Aug 9</u> , 19 <u>61</u> , and that death occurred at <u>2:40 P.M.</u> from the causes and on the date stated above.													
<b>22a. SIGNATURE</b> <u>Robert A. Hare</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>Aug 10, 61</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Robert A. Hare M.D.</u>		<b>22d. ADDRESS</b> <u>7600 Carroll Ave., T.P., Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)		<b>23b. DATE THEREOF</b> <u>Aug 11-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Ht Lincoln Bur.</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Adamsburg, Md Prince Georges, Md.</u>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Arthur S. Hare</u>				ADDRESS <u>D.C. 254 CARROLL ST NW</u>				<b>25a. REC'D BY REGISTRAR</b> DATE <u>AUG 14 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hare</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)		
a. COUNTY			e. STATE		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			b. COUNTY		
c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)		
a. COUNTY			e. STATE		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			b. COUNTY		
c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First Middle Last			Month Day Year		
5. SEX			6. COLOR OR RACE		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH		
9. AGE (In years, last birthday) yrs.			IF UNDER 1 YEAR Months Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (County & State, or foreign country)		
10b. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			INTERVAL BETWEEN ONSET AND DEATH		
527.1 DUE TO			1 year.		
Conditions, if any, which gave rise to immediate cause (b)			1 yr.		
(a), stating the underlying cause last. (c)			1 yr.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 4 Aug 1961 to 12 Aug 1961, that (I) (we) last saw the deceased alive on 4 Aug 1961, and that death occurred at 5 P.M. from the causes and on the date stated above.					
22a. SIGNATURE			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		
23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR'S SIGNATURE			25a. REC'D BY REGISTRAR		
25b. REGISTRAR'S SIGNATURE					

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

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FOR STATE  
HEALTH DEPT.

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9355 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09346

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>13 minutes</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>75 Washington Sanitarium + Hop 10115 Tenbrook Dr</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Serome</u>		First <u>NMN</u> Middle <u>Morris</u> Last		4. DATE OF DEATH Month <u>8</u> Day <u>24</u> Year <u>1961</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-31-08</u>		9. AGE (In years last birthday) <u>53</u> yrs.	
						IF UNDER 1 YEAR Months <u>53</u> Days		IF UNDER 24 HRS. Hours <u>53</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>N. Y.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Max Morris</u>				14. MOTHER'S MAIDEN NAME <u>Nettie Neuman</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Old Hosp. Record.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>PULMONARY EMBOLISM, MASSIVE</u> <u>465X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) } (e), stating the underlying cause last. DUE TO (c) } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>8-24-61</u>									
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D.		DATE SIGNED					
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG. 25, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR PARK CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>EMERSON N. J.</u>			
23. FUNERAL DIRECTOR <u>B. Dingus &amp; Son</u>				ADDRESS <u>3501-145th NW</u>		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	
						DATE <u>AUG 28 '61</u>			

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2555 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(M)

(1)

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital by the attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
9356  
CERTIFICATE OF DEATH  
09347

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN lb <b>D.O.A.</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Richard</b> Last <b>Mulligan</b>				4. DATE OF DEATH Month <b>August</b> Day <b>22</b> Year <b>1961</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 1, 1927</b>			
9. AGE (In years last birthday) <b>33 yrs.</b>		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>21</b> Hours <b></b> Min. <b></b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Glazier</b>				10b. KIND OF BUSINESS OR INDUSTRY					
13. FATHER'S NAME <b>Harry E. Mulligan</b>				14. MOTHER'S MAIDEN NAME <b>Nora Earp</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic coronary atherosclerosis</b> DUE TO (c) <b></b>								INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days.</b> <b>4 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>May 13, 1957</b> to <b>Aug 22, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 1, 1961</b> , and that death occurred at <b>7:45 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Richard A. Yates, MD</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8-23-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Richard A. Yates, MD</b>				22d. ADDRESS <b>Old Baltimore Road, Olney, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/25/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Neelsville Church Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Neelsville, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>AUG 28 '61</b>			
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>					

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1828

CERTIFICATE OF DEATH

1828

Thomas Henry Thompson

May 13, 1828

Robert A. Thompson

Robert A. Thompson, aged 21 years, died on May 13, 1828, at his residence in the town of Newville, Maryland. He was a son of Thomas Henry Thompson and Mary Ann Thompson, nee Smith. He was a member of the Methodist Episcopal Church, and was a communicant. He was buried in the cemetery of the same church on May 15, 1828.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9357				CERTIFICATE OF DEATH				09348			
1. PLACE OF DEATH a. COUNTY Montgomery						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital						d. STREET ADDRESS 3402 13th Place, S.E. Apt 101					
3. NAME OF DECEASED (Type or print) Baby Boy NAULT						4. DATE OF DEATH August 27 19 61					
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-24-61		9. AGE (In years last birthday) yrs. 3		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Bethesda, Maryland			
13. FATHER'S NAME George Arthur Nault				14. MOTHER'S MAIDEN NAME Margaret Ann Howard				12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. George A. Nault Same as #2 above				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Disease, congenital, Cyanotic</u> 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 24, 19 61, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 27, 1961, and that death occurred at 3:15 AM, from the causes and on the date stated above.											
22a. SIGNATURE Lawrence G. Thorne M.D.						22b. DATE SIGNED August 28, 1961					
22c. PHYSICIAN'S NAME (Type) Lawrence G. Thorne, LT MC USN						22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 30 August 1961				23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet			
23d. LOCATION (City, town or county) Washington				23e. REC'D BY REGISTRAR DATE AUG 30 '61				23f. REGISTRAR'S SIGNATURE Arthur S. Thorne			
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Brother, 1661 Good Hope Rd. S.E. D.C.											

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TO HOST OR ATTENDING PHYSICIAN: The law requires the death certificate be executed within 24 hours after death. A15 (4) may be retained by the hospital or attending physician. 15M 9/60 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9358  
CERTIFICATE OF DEATH  
09349

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b><br>c. LENGTH OF STAY IN 1b <b>28 Days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>New York</b> b. COUNTY <b>✓</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Apalachin</b><br>d. STREET ADDRESS <b>19 Meadow Lane</b> 69X-1<br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br><b>NANCY</b> First <b>MARIE</b> Middle <b>NNNIE</b> Last  |  | 4. DATE OF DEATH<br><b>August 9, 1961</b> Month <b>August</b> Day <b>9</b> Year <b>1961</b>                                     |  | 9. AGE (In years last birthday) <b>1</b> yrs. IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b> IF UNDER 24 HRS. Hours <b>3</b> Min.   |  |  |  |
| 5. SEX <b>Female</b>   |  | 6. COLOR OR RACE <b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None (Child)</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>   |  | 11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>  |  |  |  |
| 13. FATHER'S NAME <b>Eugene R. Ninnie</b>  |  | 14. MOTHER'S MAIDEN NAME <b>Elizabeth Lang</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)  |  | 16. SOCIAL SECURITY NO. <b>None</b>   |  | 17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY: <b>Tetralogy of Fallot</b><br><b>754.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>INTERVAL BETWEEN ONSET AND DEATH <b>Congenital</b> |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)                                     |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                          |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  |  |
| 20f. (City or town)  |  | (County)  |  | (State)  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 12, 1961</b> to <b>August 9, 1961</b> that (I) (we) last saw the deceased alive on <b>August 9, 1961</b> , and that death occurred at <b>1:47 PM</b> from the causes and on the date stated above.   |  |   |  |  |  |  |  |
| 22a. SIGNATURE <b>Richard P. Anderson</b> M.D.   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22b. DATE SIGNED <b>8-10-61</b>  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>RICHARD P. ANDERSON, M.D.</b>  |  | 22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Trans. 8/10/61</b>   |  | 23b. DATE THEREOF   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>St. Joachims Cemetery</b>  |  |  |  |
| 23d. LOCATION (City, town or county) <b>Beacon, New York</b>   |  | (State)   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>   |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR <b>AUG 14 '61</b>  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>  |  |   |  |  |  |  |  |

00310

00310



Montgomery  
 Bethesda  
 The Clinical Center  
 10 Madison Lane  
 Bethesda  
 New York

MARY MARIE WINNIE  
 August 2, 1960  
 August 2, 1960  
 August 2, 1960

Female White  
 Home (Child)  
 Eugene H. Hinkle  
 Home  
 The Medical Record  
 The Clinical Center, Bethesda, Maryland  
 Bethesda, Maryland  
 Bethesda, Maryland

August 2, 1960  
 July 12, 1960  
 August 2, 1960

Robert A. Humphrey, Bethesda, Maryland  
 Ronald-Lynn, 8104-1 St. Joseph's Cemetery, Bethesda, New York  
 The Clinical Center, Bethesda, Maryland  
 The Clinical Center, Bethesda, Maryland  
 The Clinical Center, Bethesda, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be detached for use as the burial-transit permit. In any event, within 72 hours after death, the certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9359 CERTIFICATE OF DEATH 09350

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>New York</b> b. COUNTY <b>69X-3</b>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>  |  | c. LENGTH OF STAY IN 1b <b>1 hr.</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Wash. Saint Hosp.</b>  |  | e. STREET ADDRESS <b>197-13 89th Rd</b>  |  |
| 3. NAME OF DECEASED (Type or print) <b>MARIE</b>   |  | 4. DATE OF DEATH <b>8-6-1961</b>   |  |
| 5. SEX <b>F</b>  |  | 6. COLOR OR RACE <b>W</b>  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <b>4-1-88</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.S. Wf</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country) <b>Lithuania</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>  |  |
| 13. FATHER'S NAME <b>FRED HESS</b>   |  | 14. MOTHER'S MAIDEN NAME <b>ELIZABETH WELZ</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |  | 16. SOCIAL SECURITY NO. <b>Address</b>   |  |
| 17. INFORMANT <b>MRS. Emma M. Montay</b>   |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Artery Occlusion + Ventricular Fibrillation</b><br>DUE TO <b>420.1</b><br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.<br>(b) <b>Coronary Sclerosis</b><br>DUE TO <b>generalized Arteriosclerosis</b><br>(c) <b>several years</b> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Coronary NOTIFIED AND APPROVED</b>   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour e.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>2:45 PM Aug 6, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 6, 1961</b> , and that death occurred at <b>8:50 PM</b> , from the causes and on the date stated above. |  |  |  |
| 22a. SIGNATURE <b>Marvin L. Kolkin</b> M.D.  |  | 22b. DATE SIGNED   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>MARVIN L. KOLKIN</b>   |  | 22d. ADDRESS <b>1015 SPRING STREET, S.S., Md.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |  | 23b. DATE THEREOF <b>8/10/61</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>LUTHERAN CEMETERY</b>  |  | 23d. LOCATION (City, town or county) (State) <b>MIDDLE VILLAGE LONG ISLAND, N.Y.</b>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b> ADDRESS <b>Maryland</b>   |  | 25a. REC'D BY REGISTRAR <b>AUG 9 '61</b>   |  |
| 25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>  |  | DATE <b>AUG 9 '61</b>  |  |

Warner E. Pumphrey, Inc. 8434 Georgia Ave., Silver Spring

2322

(M)

(I)

FRED HESS  
OWN HOME  
ELIZABETH WALKER



# 1 FOR STATE HEALTH DEPT. M I TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. VS. A15ME 5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 9360 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09351

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Mont</b>                       |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>  |  |   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>5620 Woodway Drive</b>  |  |   |  | d. STREET ADDRESS <b>5620 Woodway Drive</b>  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Lois Nelson Noble</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>8</b> Day <b>14</b> Year <b>1961</b>  |  |   |  |
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>1/2/13</b>  |  |
| 9. AGE (In years last birthday) <b>48</b> yrs.  |  | IF UNDER 1 YEAR<br>Months <b>8</b> Days <b>14</b>   |  | IF UNDER 24 HRS.<br>Hours <b>19</b> Min. <b>61</b>   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country) <b>Washington State</b>         |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |   |  |  |  |   |  |
| 13. FATHER'S NAME <b>Jay W. Nelson</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME <b>Lena McIntire</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  |   |  | 16. SOCIAL SECURITY NO. <b>None</b>  |  | 17. INFORMANT <b>Husband - W. B. Noble</b>                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Fat embolism</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>hepatic fatty metamorphosis</b><br>DUE TO (c) <b>Cronic alcoholism</b>  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |   |  | 2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Hour <b>e.m.</b> Month, Day, Year <b>19</b>  |  | 2Dd. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                      |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Frank J. Broschant</b>  |  |   |  | DATE SIGNED <b>8-15-61</b>   |  |   |  |
| EXAMINER'S NAME (Type) <b>FRANK J. Broschant</b>  |  |   |  | Address (Street, city, town, or county)  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 22b. DATE THEREOF <b>8/16/61</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>  |  | 22d. LOCATION (City, town, or country) (State) <b>Rockville, Maryland</b> |  |
| 23. FUNERAL DIRECTOR <b>Robert A. Pumphrey, Bethesda, Maryland</b>  |  |   |  | 24a. REC'D BY REGISTRAR <b>AUG 17 '61</b>  |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>                         |  |

RECEIVED  
JAN 10 1951

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10351

|                 |  |                                    |  |
|-----------------|--|------------------------------------|--|
| Name            |  | Address                            |  |
| Mr. J. H. Smith |  | 123 Main St.,<br>Springfield, Ill. |  |
| Age             |  | Sex                                |  |
| 45              |  | Male                               |  |
| Height          |  | Weight                             |  |
| 5' 10"          |  | 175 lbs.                           |  |
| Blood Pressure  |  | Pulse                              |  |
| 120/80          |  | 72                                 |  |
| Temperature     |  | Respiration                        |  |
| 98.6            |  | 18                                 |  |
| Diagnosis       |  | Remarks                            |  |
| Hypertension    |  | Patient stable.                    |  |

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9361

03352

|   |  |  |  |  |  |                               |  |  |  |   |  |   |  |  |  |
|---|--|--|--|--|--|-------------------------------|--|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY IN 1b <u>12 hours</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>d. STREET ADDRESS <u>2400 Colesville-Beltsville Rd</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                               |  |  |  |   |  |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br><u>Evon Carter Noonan</u>  |  | 4. DATE OF DEATH<br>Month <u>Aug.</u> Day <u>23</u> Year <u>1961</u> |  | 5. SEX <u>Male</u>   |  | 6. COLOR OR RACE <u>White</u> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>Month <u>6</u> Day <u>4</u> Year <u>'12</u> |  | 9. AGE (In years last birthday) <u>49</u> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months <u>4</u> Days <u>23</u> Hours <u>14</u> Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chemist</u>  |  |  |  | 11. BIRTHPLACE (County & State, or foreign country) <u>N.O.L. U.S. GOVT. Vermont</u>   |  |                               |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>  |  |   |  |   |  |  |  |
| 13. FATHER'S NAME <u>William Noonan</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Fannie Sears</u>   |  |                               |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)                                       |  |   |  | 16. SOCIAL SECURITY NO. <u>Hosp. Records</u>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>420.1</u> <u>coronary thrombosis</u><br>DUE TO (b) <u>coronary atherosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> |  |  |  |  |  |                               |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>14 hr.</u>   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |  |  |  |  |  |                               |  |  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <u>19</u><br>p.m.  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |                               |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |   |  | 20f. (City or town) (County) (State)  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8-22</u> , 19 <u>61</u> to <u>8-23</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>8-23</u> , 19 <u>61</u> , and that death occurred at <u>7:15</u> A.M. from the causes and on the date stated above.  |  |  |  |  |  |                               |  |  |  |   |  |   |  |  |  |
| 22a. SIGNATURE <u>Veronica Troost</u> M.D.  |  |  |  |  |  |                               |  |  |  |   |  | 22b. DATE SIGNED  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>VERONICA TROOST</u>   |  |  |  |  |  |                               |  |  |  |   |  | 22d. ADDRESS <u>10236 N. H. Ave. Silver Spring</u>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  |  |  | 23b. DATE THEREOF <u>Aug. 28-1961</u>  |  |                               |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Sweet Memorial</u>   |  |   |  | 23d. LOCATION (City, town or county) (State) <u>Charleston - West Virginia</u>              |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kneale</u> ADDRESS <u>254 Carroll St NW DC</u>  |  |  |  |  |  |                               |  |  |  |   |  | 25a. REC'D BY REGISTRAR DATE <u>AUG 28 '61</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneale</u>                         |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

56821

1951

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "William" and "Fannie" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificates be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
09353

|  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Montgomery   |  | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Bethesda (Rural)   |  | c. LENGTH OF STAY IN 1b<br>46 days  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br>Virginia |  | b. COUNTY<br>Chincoteague                                      |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>U. S. Naval Hospital   |  | e. STREET ADDRESS<br>Ridge Road  |  | f. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>Myrtle   |  | First<br>Virginia  |  | Middle<br>Novak   |  | Last<br>August  |  | 4. DATE OF DEATH<br>Month<br>11<br>Day<br>19<br>Year<br>61     |  |
| 5. SEX<br>Female   |  | 6. COLOR OR RACE<br>Caucasian  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>3-27-17   |  | 9. AGE (In years last birthday)<br>44 yrs.                     |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (County & State, or foreign country)<br>Virginia   |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  |  |
| 13. FATHER'S NAME<br>Earl Birch  |  | 14. MOTHER'S MAIDEN NAME<br>Elsie Bowden   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>NO  |  | 16. SOCIAL SECURITY NO.<br>(If available give war or dates of service)  |  | 17. INFORMANT<br>Frank J. Novak<br>Address<br>Same as #2 above |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Carcinomatous</i><br>175.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of the ovary.</i><br>DUE TO (c) |  | INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br>19   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)<br>(County)<br>(State)  |  |  |  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 26, 1961 to August 11, 1961 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 11, 1961, and that death occurred at 5:00 PM from the causes and on the date stated above.        |  | 22a. SIGNATURE<br><i>Arthur O. Anctil, Jr.</i><br>M.D.<br>22c. PHYSICIAN'S NAME (Type)<br>Arthur O. Anctil, Jr. LT MC USN                                      |  | 22b. DATE SIGNED<br>August 12, 1961   |  | 22d. ADDRESS<br>U. S. Naval Hospital, Bethesda, Md.   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE THEREOF<br>August 16, 1961   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Greenwood Cemetery  |  | 23d. LOCATION (City, town or county)<br>Chincoteague  |  | (State)<br>Va  |  |
| 24. FUNERAL HOME'S SIGNATURE<br><i>Salver Funeral Home</i><br>Salver Funeral Home, Chincoteague, Va.   |  | 25a. DATED BY REGISTRAR<br>AUG 16 61<br>DATE   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Kraus</i>  |  |   |  |  |  |

1935

1935

(M)

Chloroform (Anhydrous) 100 gms

U. S. Naval Hospital, 100 gms

U. S. Naval Hospital, 100 gms

U. S. Naval Hospital, 100 gms

U. S. Naval Hospital, 100 gms

U. S. Naval Hospital, 100 gms

U. S. Naval Hospital, 100 gms

U. S. Naval Hospital, 100 gms

U. S. Naval Hospital, 100 gms

U. S. Naval Hospital, 100 gms



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9363

09354

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u><br>c. LENGTH OF STAY IN 1b <u>25 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u> |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission)<br>a. STATE <u>Virginia</u> b. COUNTY _____<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Great Falls</u><br>d. STREET ADDRESS _____<br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br><u>Willard</u> <u>Moore</u> <u>Oliver</u>  |  | <b>4. DATE OF DEATH</b><br>Month <u>August</u> Day <u>21</u> Year <u>1961</u>  |  | <b>5. SEX</b> <u>Male</u><br><b>6. COLOR OR RACE</b> <u>Caucasian</u><br><b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Electrician</u>  |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>Virginia</u>  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>USA</u>  |  |  |  |
| <b>13. FATHER'S NAME</b><br><u>Benjamin Oliver</u>  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Unknown</u>  |  | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u><br><b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>   |  |  |  |
| <b>17. INFORMANT</b><br><u>(S) Charles Oliver 4215 S. Four Mile Dr. Virginia</u>  |  | <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrhythmia</u><br>(b) <u>metastasis</u><br>(c) <u>Bronchogenic Carcinoma</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____ |  | INTERVAL BETWEEN ONSET AND DEATH _____<br><b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>  |  | <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of Injury in Part I or Part II of item 18.) _____   |  |  |  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____  |  |  |  |
| <b>20f. (City or town)</b> _____  |  | <b>20g. (County)</b> _____   |  | <b>20h. (State)</b> _____  |  |  |  |
| <b>21. I certify that</b> <del>10</del> (this hospital) attended the deceased from <u>July 27</u> , 19 <u>61</u> , to <u>August 21</u> , 19 <u>61</u> , that <del>1</del> (we) last saw the deceased alive on <u>August 21</u> , 19 <u>61</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above.                             |  |  |  |  |  |  |  |
| <b>22a. SIGNATURE</b><br><u>D. L. Kettering</u>   |  | <b>22b. DATE SIGNED</b><br><u>22 August 1961</u>   |  | <b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>D. L. KETTERING, LT MC USN</u>   |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>   |  | <b>23b. DATE THEREOF</b><br><u>25 August 1961</u>  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Arnon Cemetery</u>   |  |  |  |
| <b>23d. LOCATION</b> (City, town or county)<br><u>Great Falls</u>   |  | <b>23e. (State)</b><br><u>Va.</u>  |  | <b>24. FURNERAL DIRECTOR'S SIGNATURE</b><br><u>CC Pearson</u>  |  |  |  |
| <b>24a. ADDRESS</b><br><u>Pearson's 472 N. Washington, Falls Church, Va.</u>  |  | <b>25a. REC'D BY REGISTRAR</b><br>DATE <u>AUG 24 '61</u>   |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Arthur S. K...</u>   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificates be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00300

00300

(M)

(I)

U. S. Army Medical Department  
The Surgeon General  
Washington, D. C.  
20305  
Dear Sir:  
Enclosed for you are two copies of a report  
dated 10/1/50, and captioned as above.  
Very respectfully,  
The Surgeon General  
U. S. Army Medical Department  
Washington, D. C.  
20305

Enclosure  
10/1/50  
U. S. Army Medical Department  
The Surgeon General  
Washington, D. C.  
20305  
Very respectfully,  
The Surgeon General  
U. S. Army Medical Department  
Washington, D. C.  
20305

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificates be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9364

09355

|   |                                  |   |  |   |   |  |  |
|---|----------------------------------|---|--|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |                                  | c. LENGTH OF STAY in 1b<br><b>10 months</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |   | 46   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>5517 Hoover Street</b>   |                                  |   |  | d. STREET ADDRESS<br><b>5517 Hoover Street</b>  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>James E. O'Neill</b>   |                                  |   |  | 4. DATE OF DEATH<br><b>August 4 19 61</b>   |   |  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1-15-1884</b>                                   |   | 9. AGE (In years last birthday)<br><b>77 yrs.</b> | IF UNDER 1 YEAR<br>Months Days   | IF UNDER 24 HRS.<br>Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Ret'd Mail Room</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Trinity College</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Washington, D. C.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>Edward J. O'Neill</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Bridget Galvin</b>   |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>579-10-5946</b>   |  | 17. INFORMANT<br><b>Mary M. Usilton</b>   |   | Address <b>5517 Hoover St. Bethesda, Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arterio-sclerotic heart</b><br>(c) <b>generalized arterio-sclerosis</b> |                                  |   |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hr</b><br><b>?</b><br><b>?</b>                        |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br><b>Paralysis of the muscles used in swallowing</b>   |                                  |   |  |   |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |  |  |
| 20c. TIME OF INJURY<br>Hour e.m.<br>p.m.  | Month, Day, Year<br><b>19</b>    | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State)              |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Feb 1, 1961</b> , to <b>Aug 4, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 2, 1961</b> , and that death occurred at <b>2 P.M.</b> from the causes and on the date stated above.   |                                  |   |  |   |   |  |  |
| 22a. SIGNATURE<br><b>Walter K. Angevine</b> M.D.  |                                  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>               |   | 22b. DATE SIGNED<br><b>Aug 4, 1961</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>WALTER K. ANGEVINE, M.D.</b>   |                                  |   |  | 22d. ADDRESS<br><b>6300-13th ST, N.W., WASH., D.C.</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>8-7-61</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>  |   | 23d. LOCATION (City, town or county) (State)<br><b>Washington, D. C.</b>                       |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Francis J. Collins</b>   |                                  |   |  | ADDRESS<br><b>3821-14th St. N.W. Wash. DC</b>   |   | 25a. REC'D BY REGISTRAR<br><b>DATE AUG 8 '61</b>   |  |
|   |                                  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |   |  |  |

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FOR STATE  
HEALTH DEPT.

1  
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9365 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09356

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>              |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>   |  |
| c. LENGTH OF STAY IN 1b <b>DOA</b>   |  | d. STREET ADDRESS <b>Stewardtown Rd.</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>B &amp; O R R tracks.</b>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <b>Buell Owens</b>   |  | 4. DATE OF DEATH <b>8/26/61</b>  |  |
| 5. SEX <b>male</b>   |  | 6. COLOR OR RACE <b>Negro</b>  |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <b>8/17/25</b>  |  |
| 9. AGE (in years last birthday) <b>36 yrs.</b>   |  | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>   |  |
| 11. BIRTHPLACE (State or foreign country) <b>USA</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 13. FATHER'S NAME <b>George Owens</b>  |  | 14. MOTHER'S MAIDEN NAME <b>Augusta Barnes</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>   |  | 16. SOCIAL SECURITY NO. <b>Police record</b>   |  |
| 17. INFORMANT <b>Police record</b>   |  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multiple injuries, extreme</b><br><b>812X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Head partially decapated</b><br>(a), stating the underlying cause last. DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Struck by passenger train while walking on RR tract</b> |  |
| 20c. TIME OF INJURY Month, Day, Year <b>11:25 PM 8/26/61</b>   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>                                      |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>B &amp; O R R</b>  |  | 20f. (City or town) <b>Gaithersburg</b> (County) <b>Montg.</b> (State) <b>Md.</b>  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |  |  |
| ACTUAL SIGNATURE <b>Frank J. Broschart</b>   |  | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |
| EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>8/27/61</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 22b. DATE THEREOF <b>8/30/61</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>  |  | 22d. LOCATION (City, town, or country) (State) <b>Arlington, Va</b>  |  |
| 23. FUNERAL DIRECTOR <b>Robert L. Snowden</b>  |  | 24a. REC'D BY REGISTRAR <b>Rockville Md.</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with four PM's. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 9366 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09357

FOR STATE  
HEALTH DEPT.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>montg</u> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Germantown - R-2</u>  |  |   |  | c. LENGTH OF STAY in 1b<br><u>2 1/2 hrs</u>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Black Rock Rd</u>   |  |   |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>12 Bethesda</u>                             |  |   |  |
| f. STREET ADDRESS<br><u>10508 Montrose Ave - Apt No 3</u>  |  |   |  | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                     |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>Novell Wordsworth Page</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>Aug</u> Day <u>14</u> Year <u>1961</u>  |  |   |  |
| 5. SEX<br><u>male</u>  |  | 6. COLOR OR RACE<br><u>white</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><u>7-12-1904</u>          |  |
| 9. AGE (In years, last birthday)<br><u>57</u> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>  |  | 11. IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.C.</u> |  |
| 10a. USUAL OCCUPATION (Give kind of work, do not put more than 100 characters)<br><u>Reporter for Industrial News Br.</u>  |  |   |  | 11. BIRTHPLACE (State or foreign country)<br><u>U.S.C.</u>   |  |   |  |
| 13. FATHER'S NAME<br><u>Charles W. Page</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Estlie Bethel</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br><u>No</u>   |  |   |  | 16. SOCIAL SECURITY NO.<br><u>226-20-7068</u>  |  |   |  |
| 17. INFORMANT<br><u>Jeane Page (wife)</u>  |  |   |  | Address<br><u>Illin 2</u>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>4201 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>  </u><br>(c) <u>  </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> |  |   |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>  </u>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)          |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>   |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   |  | DATE SIGNED <u>8-14-61</u>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  |   |  | 22b. DATE THEREOF<br><u>8/18/61</u>  |  |   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Parklawn Cemetery</u>   |  |   |  | 22d. LOCATION (City, town, or country) (State)<br><u>Rockville, Maryland</u>   |  |   |  |
| 23. FUNERAL DIRECTOR<br><u>Robert A. Pumphrey</u>  |  |   |  | 24a. REC'D BY REGISTRAR<br><u>Bethesda, Maryland</u>   |  |   |  |
| 24b. REGISTRAR'S SIGNATURE<br><u>Arthur L. Haines</u>  |  |   |  | DATE <u>AUG 21 '61</u>   |  |   |  |

TO DEPUTY LOCAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

9367

09358

|  |                           |  |                                     |   |  |  |  |
|--|---------------------------|--|-------------------------------------|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                           |  |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>New Jersey</u> b. COUNTY <u>Hopewell</u> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>takoma Park</u>  |                           |  |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hopewell</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oak Haven Convalescent Home.</u>   |                           |  |                                     | d. STREET ADDRESS <u>67X</u>  |  |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>Annie French Palmer</u>  |                           |  |                                     | 4. DATE OF DEATH Month Day Year<br><u>Aug 24 1961</u>   |  |  |  |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 13 1876</u> |   | 9. AGE (If years last birthday) <u>85</u> yrs. | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.                       |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                           |  |                                     | 10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>   |  |
| 13. FATHER'S NAME <u>Harvey Roop.</u>  |                           |  |                                     | 14. MOTHER'S MARDEN NAME <u>Agnes Hall</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)  |                           |  |                                     | 16. SOCIAL SECURITY NO. <u>no</u>   |  | 17. INFORMANT Address <u>Mrs. Edith Popeño, 9502 Thorn Hill Rd., Silver Sp., Md.</u> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><u>332X</u> IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u><br>DUE TO (b) <u>Generalized arteriosclerosis</u><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. |                           |  |                                     |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>7 months</u><br><u>Several years</u>          |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                           |  |                                     |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                           |  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                     | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 7, 1961</u> to <u>August 24, 1961</u> , that (I) (we) last saw the deceased alive on <u>August 18, 1961</u> , and that death occurred at <u>8:15 P.M.</u> from the causes and on the date stated above.   |                           |  |                                     |   |  |  |  |
| 22a. SIGNATURE <u>Bennet A. Porter, Jr.</u>  |                           |  |                                     | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>          |  | 22b. DATE SIGNED <u>Aug. 24, 1961</u>  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr., M.D.</u>  |                           |  |                                     | 22d. ADDRESS <u>9301 Coleridge Rd., Silver Spring Md.</u>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |                           | 23b. DATE THEREOF <u>8/25/61</u>   |                                     | 23c. NAME OF CEMETERY OR CREMATORY <u>Highlands Cemetery</u>  |  | 23d. LOCATION (City, town, or county) (State) <u>Hopewell, N.J.</u>                  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>S. H. Hines Co. 2901-14th ST. NW. D.C.</u>   |                           |  |                                     | 25a. REC'D BY REGISTRAR DATE <u>AUG 28 '61</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>                                   |  |

TO HOSPITAL: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificates be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

MEDICAL CERTIFICATION

|   |  |  |  |  |  |  |  |  |  |  |  |
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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |  |  |  |  |  |  |
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |  |  |  |  |  |  |  |  |  |
| 9368  |  |  |  |  |  |  |  |  |  |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  |  |  |
| Items 23 File 6292 8/10/61  |  |  |  |  |  |  |  |  |  |  |  |
| 09359   |  |  |  |  |  |  |  |  |  |  |  |
| 1. PLACE OF DEATH   |  |  |  |  |  |  |  |  |  |  |  |
| a. COUNTY   |  |  |  |  |  |  |  |  |  |  |  |
| Montgomery  |  |  |  |  |  |  |  |  |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  |  |  |  |  |  |  |  |  |  |  |  |
| Bethesda (Rural)  |  |  |  |  |  |  |  |  |  |  |  |
| c. LENGTH OF STAY IN 1b   |  |  |  |  |  |  |  |  |  |  |  |
| 17 days   |  |  |  |  |  |  |  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  |  |  |  |  |  |  |  |  |  |  |  |
| U. S. Naval Hospital  |  |  |  |  |  |  |  |  |  |  |  |
| 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)   |  |  |  |  |  |  |  |  |  |  |  |
| a. STATE  |  |  |  |  |  |  |  |  |  |  |  |
| Maryland  |  |  |  |  |  |  |  |  |  |  |  |
| b. COUNTY   |  |  |  |  |  |  |  |  |  |  |  |
| Montgomery  |  |  |  |  |  |  |  |  |  |  |  |
| c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  |  |  |  |  |  |  |  |  |  |  |  |
| Bethesda  |  |  |  |  |  |  |  |  |  |  |  |
| d. STREET ADDRESS   |  |  |  |  |  |  |  |  |  |  |  |
| 9209 Bulls Run Pkwy   |  |  |  |  |  |  |  |  |  |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)   |  |  |  |  |  |  |  |  |  |  |  |
| First Middle Last   |  |  |  |  |  |  |  |  |  |  |  |
| Thad Patrick  |  |  |  |  |  |  |  |  |  |  |  |
| 4. DATE OF DEATH  |  |  |  |  |  |  |  |  |  |  |  |
| Month Day Year  |  |  |  |  |  |  |  |  |  |  |  |
| August 3 1961   |  |  |  |  |  |  |  |  |  |  |  |
| 5. SEX  |  |  |  |  |  |  |  |  |  |  |  |
| Male  |  |  |  |  |  |  |  |  |  |  |  |
| 6. COLOR OR RACE  |  |  |  |  |  |  |  |  |  |  |  |
| Caucasian   |  |  |  |  |  |  |  |  |  |  |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |  |  |
| 8. DATE OF BIRTH  |  |  |  |  |  |  |  |  |  |  |  |
| 9-21-25   |  |  |  |  |  |  |  |  |  |  |  |
| 9. AGE (In years last birthday)   |  |  |  |  |  |  |  |  |  |  |  |
| 35 yrs.   |  |  |  |  |  |  |  |  |  |  |  |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |  |  |  |  |  |  |  |  |  |  |
| Sanitary Engineer   |  |  |  |  |  |  |  |  |  |  |  |
| 11. BIRTHPLACE (County & State, or foreign country)   |  |  |  |  |  |  |  |  |  |  |  |
| Texas   |  |  |  |  |  |  |  |  |  |  |  |
| 12. CITIZEN OF WHAT COUNTRY?  |  |  |  |  |  |  |  |  |  |  |  |
| USA   |  |  |  |  |  |  |  |  |  |  |  |
| 13. FATHER'S NAME   |  |  |  |  |  |  |  |  |  |  |  |
| William T. Patrick  |  |  |  |  |  |  |  |  |  |  |  |
| 14. MOTHER'S MAIDEN NAME  |  |  |  |  |  |  |  |  |  |  |  |
| Lula Bond   |  |  |  |  |  |  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)  |  |  |  |  |  |  |  |  |  |  |  |
| Yes WW II   |  |  |  |  |  |  |  |  |  |  |  |
| 16. SOCIAL SECURITY NO.   |  |  |  |  |  |  |  |  |  |  |  |
| 17. INFORMANT   |  |  |  |  |  |  |  |  |  |  |  |
| Carolyn M. Patrick Same as #2 above   |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (a) SUBARACHNOID HEMORRHAGE   |  |  |  |  |  |  |  |  |  |  |  |
| 330X DUE TO   |  |  |  |  |  |  |  |  |  |  |  |
| (b) RUPTURED INTRACRANIAL ANEURYSM  |  |  |  |  |  |  |  |  |  |  |  |
| DUE TO  |  |  |  |  |  |  |  |  |  |  |  |
| (c)   |  |  |  |  |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  |  |  |  |  |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |  |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year  |  |  |  |  |  |  |  |  |  |  |  |
| Hour e.m. p.m. 19   |  |  |  |  |  |  |  |  |  |  |  |
| 20d. INJURY OCCURRED  |  |  |  |  |  |  |  |  |  |  |  |
| While Not While at work <input type="checkbox"/> et work <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |  |  |  |  |  |  |  |  |  |  |
| 20f. (City or town) (County) (State)  |  |  |  |  |  |  |  |  |  |  |  |
| 21. I certify that (this hospital) attended the deceased from July 17, 1961 to August 3, 1961, that (we) last saw the deceased alive on August 3, 1961, and that death occurred at 9:40 PM, from the causes and on the date stated above. |  |  |  |  |  |  |  |  |  |  |  |
| 22a. SIGNATURE  |  |  |  |  |  |  |  |  |  |  |  |
| R.W. Mackie   |  |  |  |  |  |  |  |  |  |  |  |
| 22b. DATE SIGNED  |  |  |  |  |  |  |  |  |  |  |  |
| August 4, 1961  |  |  |  |  |  |  |  |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)  |  |  |  |  |  |  |  |  |  |  |  |
| R.W. MACKIE CAPT MC USN   |  |  |  |  |  |  |  |  |  |  |  |
| 22d. ADDRESS  |  |  |  |  |  |  |  |  |  |  |  |
| U. S. Naval Hospital, Bethesda, Md.   |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  |  |  |  |  |  |  |  |  |  |
| Burial  |  |  |  |  |  |  |  |  |  |  |  |
| 23b. DATE THEREOF   |  |  |  |  |  |  |  |  |  |  |  |
| 8/8/61  |  |  |  |  |  |  |  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  |  |  |  |  |  |  |  |  |  |  |
| Capitol Mem. Gardens  |  |  |  |  |  |  |  |  |  |  |  |
| 23d. LOCATION (City, town or county) (State)  |  |  |  |  |  |  |  |  |  |  |  |
| Austin, Texas   |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE  |  |  |  |  |  |  |  |  |  |  |  |
| Robert A. Pumphrey  |  |  |  |  |  |  |  |  |  |  |  |
| 24b. ADDRESS  |  |  |  |  |  |  |  |  |  |  |  |
| Bethesda, Maryland  |  |  |  |  |  |  |  |  |  |  |  |
| 25a. REC'D BY REGISTRAR   |  |  |  |  |  |  |  |  |  |  |  |
| AUG 7 '61   |  |  |  |  |  |  |  |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |  |  |  |  |  |  |
| Arthur S. Hume  |  |  |  |  |  |  |  |  |  |  |  |



8388

8388

Montgomery

Montgomery

Beckman (Harris)

Beckman (Harris)

U. S. Naval Hospital

U. S. Naval Hospital

Tracy

Tracy

Constitution

Constitution

James

James

William T. Patrick

William T. Patrick

Wm II

Wm II

Quarantine Station

Quarantine Station

*Handwritten signature*

July 17

U. S. Naval Hospital, Bethesda, Md.

Robert A. Thompson, 1957  
Bethesda, Maryland



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9369

## CERTIFICATE OF DEATH

09360

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY IN 1b <u>MARYLAND</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San. &amp; Hosp.</u>                            |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park, Md.</u><br>d. STREET ADDRESS <u>18202 Flower Ave -</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>JULIUS CARL PETER R</u><br>First Middle Last  |  |   |  | 4. DATE OF DEATH <u>Aug 5 1961</u><br>Month Day Year  |  |  |  |
| 5. SEX <u>Male</u>   |  | 6. COLOR OR RACE <u>white</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <u>Feb. 5 1894</u><br>Last                                  |  |
| 9. AGE (In years last birthday) <u>67</u> yrs.   |  | IF UNDER 1 YEAR<br>Months Days  |  | IF UNDER 24 HRS.<br>Hours Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Reverend &amp; Healer</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country) <u>Chicago, Illinois</u> |  |
| 12. CITIZEN OF WHAT COUNTRY?   |  |   |  | 13. FATHER'S NAME <u>Julius C. Peter Sr.</u>  |  |  |  |
| 14. MOTHER'S MAIDEN NAME <u>Lena Kramer</u>  |  |   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |  |  |  |
| 16. SOCIAL SECURITY NO. <u>332 X</u>   |  |   |  | 17. INFORMANT <u>Chas H Wolohin</u>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u><br>332 X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u><br>DUE TO (c) <u>Phlebotomy L. leg</u> |  |   |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>  |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8/3/61</u> to <u>8/5/61</u> , that (I) (we) last saw the deceased alive on <u>8/3/61</u> , and that death occurred on <u>8/5/61</u> M, from the causes and on the date stated above.  |  |   |  |   |  |  |  |
| 22a. SIGNATURE <u>Chas H Wolohin</u><br>M.D.   |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  | 22b. DATE SIGNED   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Chas H Wolohin</u>   |  |   |  | 22d. ADDRESS <u>7600 Carroll Ave TP</u>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE THEREOF <u>Aug-10-61</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>   |  | 23d. LOCATION (City, town or county) <u>Derrien Springs Michigan</u>         |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Hall</u>   |  |   |  | ADDRESS <u>254 Canal St NW</u>  |  | 25a. REC'D BY REGISTRAR <u>Aug 8 '61</u>                                     |  |
|  |  |   |  |   |  | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>                            |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificates be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

10000

2000

(M)

(I)

TO HOSPITAL OR AT RESIDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician. It must be retained by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/60

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                                   |  |   |  |   |  |  |  |  |  |
|---|--|-----------------------------------|--|---|--|---|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                                   |  |   |  |   |  |  |  |  |  |
| CERTIFICATE OF DEATH  |  |                                   |  |   |  |   |  |  |  |  |  |
| 9370 09361  |  |                                   |  |   |  |   |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br>MONTGOMERY  |  |                                   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br>MARYLAND |  |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>SILVER SPRING   |  |                                   |  |   |  | b. COUNTY<br>MONTGOMERY   |  |  |  |  |  |
| c. LENGTH OF STAY IN 1b<br>1  |  |                                   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>SILVER SPRING             |  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>818 GIST AVENUE   |  |                                   |  |   |  | d. STREET ADDRESS<br>818 GIST AVENUE  |  |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) MARTHA MACLEOD   |  |                                   |  |   |  | 4. DATE OF DEATH<br>AUGUST 29, 1961   |  |  |  |  |  |
| 5. SEX<br>FEMALE  |  | 6. COLOR OR RACE<br>WHITE         |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                     |  | 8. DATE OF BIRTH<br>NOVEMBER 2, 1890  |  | 9. AGE (In years last birthday)<br>70 yrs. |  | 10. IF UNDER 1 YEAR<br>Months Days           |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>TEACHER-RETIRED  |  | 10b. KIND OF BUSINESS OR INDUSTRY |  | 11. BIRTHPLACE (County & State, or foreign country)<br>NORTH CAROLINA                                     |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 13. FATHER'S NAME<br>HENRY MACLEOD         |  | 14. MOTHER'S MAIDEN NAME<br>UNKNOWN          |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO  |  |                                   |  |   |  | 16. SOCIAL SECURITY NO.<br>-----  |  |  |  |  |  |
| 17. INFORMANT<br>MR. CHARLES T. PLUNKETT  |  |                                   |  |   |  | Address<br>818 GIST AVENUE<br>SILVER SPRING, MARYLAND   |  |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MASSIVE INTESTINAL HEMORRHAGE<br>578X DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(a), stating the underlying cause last. DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>DIABETES MELLITUS<br>INTERVAL BETWEEN ONSET AND DEATH<br>18 Hrs. |  |                                   |  |   |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                  |  |  |  |  |  |
| 20c. TIME OF INJURY<br>Hour e.m.<br>p.m.  |  | Month, Day, Year<br>19            |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)<br>SILVER SPRING       |  | (County) (State)                             |  |
| 21. I certify that (I) (his hospital) attended the deceased from 29 AUG. 1961 to 29 AUG. 1961, that (I) (we) last saw the deceased alive on 29 AUG. 1961, and that death occurred at 3:00 P.M. from the causes and on the date stated above.  |  |                                   |  |   |  |   |  |  |  |  |  |
| 22a. SIGNATURE<br>LEE B. SNOW   |  |                                   |  |   |  | M.D.<br>ATTENDING PHYS. <input checked="" type="checkbox"/>   |  | MED. DIRECTOR <input type="checkbox"/>     |  | STAFF PHYS. <input type="checkbox"/>         |  |
| 22c. PHYSICIAN'S NAME (Type)<br>LEE B. SNOW   |  |                                   |  |   |  | 22d. ADDRESS<br>7950 NEW HAMPSHIRE AVENUE   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |  | 23b. DATE THEREOF<br>9/1/61       |  | 23c. NAME OF CEMETERY OR CREMATORY<br>ARLINGTON NATIONAL CEMETERY   |  | 23d. LOCATION (City, town or county)<br>ARLINGTON, VIRGINIA   |  | 23e. REASON FOR REGISTRAR<br>AGE 31 '61    |  | 23f. REGISTRAR'S SIGNATURE<br>Arthur S. Huns |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br>Raymond H. Ziska  |  |                                   |  |   |  | 25. REGISTRAR'S SIGNATURE<br>Arthur S. Huns   |  |  |  |  |  |
| WARDER E. PUMPHREY, INC. SILVER SPRING, MARYLAND  |  |                                   |  |   |  | DATE  |  |  |  |  |  |

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18 Nov 51

Director

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11 Nov 51

WILLIAMSON NATIONAL COMPANY  
2000 NEW YORK  
NEW YORK 100  
WILLIAMSON NATIONAL COMPANY  
2000 NEW YORK  
NEW YORK 100

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9371

09362

|   |                                  |   |   |   |  |   |  |
|---|----------------------------------|---|---|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>e. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>OLNEY</b>  |                                  |   | c. LENGTH OF STAY IN 1b<br><b>14 DAYS</b> |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>GAITHERSBURG</b> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>MONTGOMERY GENERAL HOSPITAL</b>  |                                  |   |   | d. STREET ADDRESS<br><b>15 DESELLUM AVE.</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>THOMAS</b> Middle <b>HERBERT</b> Last <b>POPE</b>  |                                  |   |   | 4. DATE OF DEATH<br>Month <b>AUGUST</b> Day <b>22</b> Year <b>1961</b>  |  |   |  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>SEPT. 19, 1872</b> |   | 9. AGE (In years last birthday)<br><b>88 yrs.</b>                      | IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/>                        | IF UNDER 24 HRS.<br>Hours <input type="checkbox"/> Min. <input type="checkbox"/>             |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED- GOVERNMENT</b>   |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY         |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>MARYLAND</b> |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |
| 13. FATHER'S NAME<br><b>JOSEPH POPE</b>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>MATILDA THOMPSON</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |                                  | 16. SOCIAL SECURITY NO.<br>(If yes give year or dates of service)   |   | 17. INFORMANT<br><b>HOSPITAL RECORDS</b>  |  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Emboli, Pulmonary</b><br><b>464X</b> DUE TO <b>Thrombophlebitis, femoral, right.</b><br>Conditions, if any, which gave rise to immediate cause (b) <b>right.</b><br>(c) <b>right.</b><br>DUE TO <b>right.</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>464X</b> |                                  |   |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b>  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |   |   |   |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 10, 1961</b> to <b>Aug. 22, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug. 21, 1961</b> , and that death occurred at <b>9:21 A.M.</b> from the causes and on the date stated above.  |                                  |   |   |   |  |   |  |
| 22a. SIGNATURE<br><b>J. Schumacher</b> M.D.   |                                  |   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>               |  | 22b. DATE SIGNED<br><b>8.22.61</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>J. SCHUMACHER, M. D.</b>   |                                  |   |   | 22d. ADDRESS<br><b>GAITHERSBURG, MARYLAND</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>8-24</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>8-24 Wesley Grove Cemetery</b>   |  | 23d. LOCATION (City, town or county) (State)<br><b>Woodfield. Md.</b>                                   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Ernest C. Gartner.</b>   |                                  |   |   | ADDRESS<br><b>Gaithersburg. Md.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>AUG 24 '61</b>  |  |
|   |                                  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Ernest C. Gartner</b>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician. Page 2 must be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                               |  |  |  |  |  |  |  |   |  |
|---|--|-------------------------------|--|--|--|--|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                               |  |  |  |  |  |  |  |   |  |
| CERTIFICATE OF DEATH  |  |                               |  |  |  |  |  |  |  |   |  |
| 9372  |  |                               |  |  |  |  |  |  |  |   |  |
| 09363   |  |                               |  |  |  |  |  |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |  |                               |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Virginia</b> <b>Arlington</b> |  |  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>  |  |                               |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b>                                  |  |  |  |   |  |
| c. LENGTH OF STAY IN lb <b>31 Days</b>  |  |                               |  |  |  | d. STREET ADDRESS <b>3925 Chesterbrook Road</b>  |  |  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center</b>   |  |                               |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                     |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or print) <b>HENRY CLAY PRYOR</b>   |  |                               |  |  |  | 4. DATE OF DEATH <b>August 10, 1961</b>  |  |  |  |   |  |
| 5. SEX <b>Male</b>  |  | 6. COLOR OR RACE <b>White</b> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>April 26, 1906</b>   |  | 9. AGE (In years last birthday) <b>55</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Management Analyst</b>   |  |                               |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Army</b>  |  |  |  | 11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>                        |  |   |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |                               |  | 13. FATHER'S NAME <b>James Pryor</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Carrie Winters</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>  |  |                               |  | 16. SOCIAL SECURITY NO. <b>WW II</b>   |  |  |  | 17. INFORMANT <b>The Medical Record</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>289.1 Congestive Heart Failure With Pneumonitis</b>   |  |                               |  | INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Amyloidosis with Multiple Myeloma</b>   |  |                               |  | 2 Months   |  |  |  |  |  |   |  |
| DUE TO (c) <b>289.1</b>   |  |                               |  |  |  |  |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |                               |  |  |  |  |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                               |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |                               |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>July 10, 1961</b> to <b>August 10, 1961</b> , that (I) (we) last saw the deceased alive on <b>August 10, 1961</b> , and that death occurred at <b>10:55 AM</b> from the causes and on the date stated above. |  |                               |  |  |  |  |  |  |  |   |  |
| 22a. SIGNATURE <b>Robert H. Levin</b> M.D.  |  |                               |  |  |  | 22b. DATE SIGNED <b>8/10/61</b>  |  |  |  |   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Robert H. Levin M.D.</b>  |  |                               |  |  |  | 22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>   |  |                               |  | 23b. DATE THEREOF <b>8/14/61</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>  |  | 23d. LOCATION (City, town or county) (State) <b>Ft. Myer, Va.</b>                              |  |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>  |  |                               |  |  |  | 25a. REC'D BY REGISTRAR <b>2901 14th St. N.W. Washington 9, D.C.</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>DATE AUG 14 '61</b>  |  | <b>Arthur S. Head</b>                     |  |



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The Clinical Center

3925 Chestnutwood Road

HENRY

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THOMAS

August 10, 61

61

Male

White

April 25, 1906 25

Management Assistant

Army

Pennsylvania

USA

James Taylor

Carle Winston

Yes

None

The Clinical Center, Bethesda II, Maryland

Investigative team, Baltimore, Md. neurologists

agitation with multiple problems

2 months

August 10, 61

10:30am

July 10, 61 August 10, 61

Robert H. Levin

The Clinical Center, National Institute of Health, Bethesda II, Md.

W/1003

W/1003

The S.S. Hines Co., 2501 M St. N.W., Washington, D.C.

Bedford, Virginia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3 should be retained by the hospital or attending physician and completely filled in by the funeral director. Page 2 of 3 should be retained by the funeral director. Page 3 of 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9373

## CERTIFICATE OF DEATH

09364

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY<br>Montgomery  |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br>Virginia                                     |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Bethesda,  |  |   |  | c. LENGTH OF STAY IN 1b<br>5 days  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>U. S. Naval Hospital   |  |   |  | e. STREET ADDRESS<br>Rt # 1  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>Michael James Rentfrow  |  |   |  | 4. DATE OF DEATH<br>August 31 19 61  |  |   |  |
| 5. SEX<br>Male   |  | 6. COLOR OR RACE<br>Caucasian   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>July 18, 1961                           |  |
| 9. AGE (In years last birthday)<br>13 yrs.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Infant      |  | 11. BIRTHPLACE (County & State, or foreign country)<br>Virginia  |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA                         |  |
| 13. FATHER'S NAME<br>Jess W. Rentfrow  |  |   |  | 14. MOTHER'S MAIDEN NAME<br>Darlene M. Caldwell  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br>No   |  |   |  | 16. SOCIAL SECURITY NO.<br>17. INFORMANT<br>(M) Darlene M. Rentfrow Same as #2 above   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Congenital Heart Disease; Transposition of Great Vessels</i><br>754-05 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>of Great Vessels</i><br>DUE TO (c) |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br>19   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                        |  |
| 21. I certify that (X) (this hospital) attended the deceased from August 26, 1961, to August 31, 1961, that (X) (we) last saw the deceased alive on August 31, 1961, and that death occurred at 1:10 AM, from the causes and on the date stated above.   |  |   |  |  |  |   |  |
| 22a. SIGNATURE<br>James E. McClenathan M.D.  |  |   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                          |  | 22b. DATE SIGNED<br>August 31, 1961                         |  |
| 22c. PHYSICIAN'S NAME (Type)<br>JAMES E. MCCLLENATHAN, CDR MC USN  |  |   |  | 22d. ADDRESS<br>U. S. Naval Hospital, Bethesda, Md.  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE THEREOF<br>2 Sept 1961  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Chestnut Grove Cemetery  |  | 23d. LOCATION (City, town or county) (State)<br>Herndon Va. |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br>Green Funeral Home, Herndon, Va.   |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE SEP 5 '61  |  | 25b. REGISTRAR'S SIGNATURE<br>Arthur S. House               |  |

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

M

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|---|--|--|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |   |  |   |  |   |  |  |  |   |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  |   |  |
| Items 8 & 9 Film C292 8/31/61 mh  |  |   |  |   |  |   |  |  |  |   |  |
| 09367   |  |   |  |   |  |   |  |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>                         |  |   |  |  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |  |   |  | c. LENGTH OF STAY in lb <u>24 hrs.</u>  |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>32 Silver Spring</u> |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>   |  |   |  | d. STREET ADDRESS <u>1 Route 1 Norwood Rd.</u>  |  |   |  | a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>WARREN</u>  |  |   |  | Last <u>Riggs</u>   |  |   |  | 4. DATE OF DEATH <u>August 1</u> 19 <u>61</u>  |  |   |  |
| 5. SEX <u>Male</u>  |  | 6. COLOR OR RACE <u>C.</u>                                  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <u>August 26 1908</u>  |  | 9. AGE (In years last birthday) <u>51</u> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Min. C. Road Comm.</u> |  | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |  |  |  |   |  |
| 13. FATHER'S NAME <u>JOHN Riggs</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME <u>MARY Dorsey</u>   |  |   |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>  |  |   |  | 16. SOCIAL SECURITY NO. <u>ARMY</u>   |  |   |  | 17. INFORMANT <u>Wife Charlotte Riggs (same as above)</u>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>912.5</u> DUE TO <u>Regimentation of Brain Stem</u>  |  |   |  |   |  |   |  | <u>Sudden</u>  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Cerebral Edema</u>  |  |   |  |   |  |   |  | <u>1 Day</u>   |  |   |  |
|   |  |   |  | (c) <u>Cerebral Concussion</u>  |  |   |  | <u>1 Day</u>   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <u>C caught between air compressor &amp; truck while unloading comp.</u> |  |   |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year <u>12:42 p.m. 7-31 1961</u>  |  |   |  | 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>   |  |   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>                     |  |   |  |
|   |  |   |  | 20f. (City or town) <u>Wheaton</u> (County) <u>Montg</u> (State) <u>md</u>  |  |   |  |  |  |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <u>Frank J. Broschant</u>  |  |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  | DATE SIGNED <u>8-2-61</u>  |  |   |  |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>  |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   |  | Address (Street, city, town, or county) <u>Norbeck, Md.</u>  |  |   |  |
| 22a. BURIAL, CREMATION, REINTERMENT (city) <u>Burial</u>  |  |   |  | 22b. DATE THEREOF <u>8/6/61</u>   |  |   |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant.,</u>   |  |   |  |
|   |  |   |  |   |  |   |  | 22d. LOCATION (City, town, or country) (State) <u>Norbeck, Md.</u>                                       |  |   |  |
| 23. FUNERAL DIRECTOR <u>Robert L. Snowden</u>   |  |   |  | ADDRESS <u>Rockville, Md.</u>   |  |   |  | 24a. REC'D BY REGISTRAR <u>AUG 7 '61</u>   |  |   |  |
|   |  |   |  |   |  |   |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>  |  |   |  |

1938

1938

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Horbeck, M.

W. H. H. H.

Horville, M.

W. H. H. H.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |  |  |  |  |  |   |  |
|---|--|---|--|---|--|--|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |   |  |   |  |  |  |  |  |   |  |
| 9375 Item 7 Film G292 8/15/61 ink 09368   |  |   |  |   |  |  |  |  |  |   |  |
| CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>                    |  |  |  |  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>TAKOMA PARK</u>  |  |   |  | c. LENGTH OF STAY IN lb   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>TAKOMA PARK</u> |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>8017 BARRON</u>  |  |   |  | d. STREET ADDRESS<br><u>8017 BARRON</u>   |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Edward</u> Middle <u>A.</u> Last <u>Roberts</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>August</u> Day <u>4</u> Year <u>1961</u>   |  |  |  |  |  |   |  |
| 5. SEX<br><u>M</u>  |  | 6. COLOR OR RACE<br><u>W</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>MARCH 28, 1890</u>                                    |  | 9. AGE (In years last birthday)<br><u>71</u> yrs.  |  | IF UNDER 1 YEAR<br>Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Printing Business</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Pittsburgh Penn</u>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |   |  |
| 13. FATHER'S NAME<br><u>Eugene Roberts</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Anna Cook</u>  |  |  |  | 17. INFORMANT<br><u>Mrs. Hazel L. Roberts</u> Address <u>8017 Barron St. Takoma Park</u>               |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes give year or dates of service) <u></u>  |  |   |  | 16. SOCIAL SECURITY NO.<br><u></u>  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Fracture of Cerebral Arteries, Contusion</u><br>332 X DUE TO <u>Cerebral Thrombosis</u><br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause test. } DUE TO <u>Cerebral Arteriosclerosis</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br><u></u> |  |   |  |   |  |  |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u></u>   |  |  |  |  |  |   |  |
| 20c. TIME OF INJURY<br>Hour a.m. <u></u> p.m. <u>19</u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Jun</u>  |  | 20f. (City or town)<br><u>1961</u>   |  | (County)<br><u></u>  |  | (State)<br><u></u>  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Aug 7, 1961</u> to <u>Aug 4, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug 7, 1961</u> , and that death occurred at <u>10:15</u> M, from the causes and on the date stated above.   |  |   |  |   |  |  |  |  |  |   |  |
| 22a. SIGNATURE<br><u>Chas. H. Wolohan</u>   |  |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        |  |  |  | 22b. DATE SIGNED<br><u></u>  |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Chas. H. Wolohan</u>   |  |   |  | 22d. ADDRESS<br><u>7600 Carroll Ave Takoma Park</u>   |  |  |  |  |  |   |  |
| 23a. BURIAL CREMATION REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE THEREOF<br><u>Aug 7-1961</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>St. Luke's</u>   |  | 23d. LOCATION (City, town or county)<br><u>Blacksburg Rd. Prince Georges</u> |  | (State)<br><u>MD.</u>  |  |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Arthur S. Kross</u>  |  |   |  | ADDRESS<br><u>254 Carroll St NW WASH DC</u>   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>AUG 8 '61</u>                             |  | 25b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kross</u>   |  |   |  |

10308

8878

(M)

(I)

## CERTIFICATE OF DEATH

Reg. Dist. No. 09369

9376

|  |                                   |  |   |
|--|-----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |   |
| b. CITY OR TOWN (If outside corporate limits, write Rural and give nearest town) <u>Poolesville</u>  |                                   | c. LENGTH OF STAY IN life <u>life</u>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                                   | d. STREET ADDRESS <u>1</u>   |   |
| 3. NAME OF DECEASED (Type or print) <u>C HARLES</u> First <u>E.</u> Middle <u>ROBINSON</u> Last  |                                   | 4. DATE OF DEATH <u>AUGUST 3</u> 19 <u>61</u> Month Day Year   |   |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>Caucasian</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Apr. 27, 1884</u> 77 yrs.             |
| 9. AGE (In years last birthday) <u>77</u> yrs.   |                                   | 10. IF UNDER 1 YEAR Months Days Hours Min.   | 11. IF UNDER 24 HRS.                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>   |                                   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>  | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                                   | 13. FATHER'S NAME <u>William Robinson</u>  |   |
| 14. MOTHER'S MAIDEN NAME <u>Jeanne Hollings</u>  |                                   | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |   |
| 16. SOCIAL SECURITY NO. <u>INFORMANT</u>   |                                   | Address <u>Many Jackson -</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CACHEXIA</u><br>DUE TO <u>177X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>METASTATIC CARCINOMA</u><br>DUE TO <u>PARCINOMA OF PROSTATE</u><br>(c) <u>PARCINOMA OF PROSTATE</u> |                                   | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 months</u><br><u>4 YEARS</u><br><u>6 YEARS</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>  |                                   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |                                   | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                   | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>June</u> , 19 <u>55</u> , to <u>3 Aug</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>3 AUG</u> , 19 <u>61</u> , and that death occurred at <u>11 P. M.</u> , from the causes and on the date stated above.   |                                   |  |   |
| ACTUAL SIGNATURE <u>John G. Lawcett</u>  |                                   | ADDRESS (Street, city or town, state) <u>P.O. BOYD, MARYLAND</u>   |   |
| PHYSICIAN'S NAME (Type) <u>JOHN G. Lawcett</u>   |                                   | DATE SIGNED <u>3 AUG. 1961</u>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                                   | 22b. DATE THEREOF <u>8/7/61</u>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Elizah Methodist</u>   |                                   | 22d. LOCATION (City, town, or county) (State) <u>Poolesville, Md.</u>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Swenden</u>  |                                   | ADDRESS <u>Rockville, Md.</u>  |   |
| 24a. REC'D BY REGISTRAR <u>AUG 11 '61</u>  |                                   | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>  |   |

VS A15 (4)  
ISM 9/58

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

1938

CERTIFICATE OF DEATH

1938

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

9377

09370

|  |                               |  |                                 |  |  |  |  |
|--|-------------------------------|--|---------------------------------|--|--|--|--|
| 1. PLACE OF DEATH<br>COUNTY <u>Montgomery</u> MARYLAND   |                               |  |                                 | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>New Jersey</u><br>b. COUNTY <u>Westmont</u> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>  |                               | c. LENGTH OF STAY IN 1b <u>9 days</u>  |                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westmont</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San &amp; Hospital</u>  |                               |  |                                 | d. STREET ADDRESS <u>120 French Ave</u>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>May</u> Last <u>Robinson</u>  |                               |  |                                 | 4. DATE OF DEATH Month <u>Aug</u> Day <u>17</u> Year <u>1961</u>   |  |  |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-26-88</u> |  | 9. AGE (In years lost birthday) <u>73</u> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Teaching</u>  |                                 | 11. BIRTHPLACE (State or foreign country) <u>England</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>Cimer.</u>   |  |
| 13. FATHER'S NAME <u>Edwin Robinson</u>  |                               |  |                                 | 14. MOTHER'S MAIDEN NAME <u>Mary Morgan</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   |                               | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)   |                                 | 17. INFORMANT <u>Washington San &amp; Hosp. Takoma Park Md</u>   |  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>434 Congestive Cardiac Failure</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardema Arthritis - osteo</u> |                               |  |                                 |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>3 Months</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               |  |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>                          |                                 | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8/9</u> 19 <u>61</u> , to <u>8/17</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>8-17-</u> 19 <u>61</u> , and that death occurred at <u>4:15</u> from the causes and on the date stated above.  |                               |  |                                 |  |  |  |  |
| 22a. SIGNATURE <u>Robert A. Hare</u>   |                               |  |                                 | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>             |  | 22b. DATE SIGNED <u>8/17/61</u>  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>   |                               |  |                                 | 22d. ADDRESS <u>7600 Carroll Ave, T.Pk. Md</u>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                               | 23b. DATE THEREOF <u>August 21, 1961</u>   |                                 | 23c. NAME OF CEMETERY OR CREMATORY <u>Reconst Wood Cemetery</u>  |  | 23d. LOCATION (City, town, or county) (State) <u>Camden New Jersey</u>                         |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>   |                               |  |                                 | ADDRESS <u>254 Carroll St. W. Wash, D.C.</u>   |  | 25a. REC'D BY REGISTRAR <u>Aug 21 1961</u>   |  |
|  |                               |  |                                 | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hare</u>   |  |  |  |

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

THE UNIVERSITY OF CHICAGO PRESS



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9378

## CERTIFICATE OF DEATH

09371

|  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY IN 1b <u>3 hrs.</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>  |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u><br>d. STREET ADDRESS <u>13402 Keating Street</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <u>George Lewis Ronk, Sr.</u>  |  | <b>4. DATE OF DEATH</b><br>Month <u>August</u> Day <u>13</u> Year <u>1961</u>  |  | <b>5. SEX</b><br><u>male</u>   |  |  |  |  |  |  |  |
| <b>6. COLOR OR RACE</b><br><u>white</u>  |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | <b>8. DATE OF BIRTH</b><br><u>September 10, 1905</u>   |  |  |  |  |  |  |  |
| <b>9. AGE</b> (In years, last birthday) <u>55</u>  |  | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Assistant Manager - Montgomery County Liquor Dispensary</u> |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Virginia</u>   |  |  |  |  |  |  |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>America</u>  |  | <b>13. FATHER'S NAME</b><br><u>Columbus George Ronk</u>  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Rosa Ledbetter</u>   |  |  |  |  |  |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) <u>No</u>  |  | <b>16. SOCIAL SECURITY NO.</b><br><u>578-05-3463</u>   |  | <b>17. INFORMANT</b><br><u>Hospital Record</u>   |  |  |  |  |  |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (e), (b), and (c).)<br><table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="vertical-align: top;"> <b>PART I. DEATH WAS CAUSED BY:</b><br/> <b>IMMEDIATE CAUSE (e)</b> <u>Congestive Heart failure</u><br/> <b>420.1</b> DUE TO<br/> <b>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.</b><br/>                 (b) <u>Myocardial infarction</u><br/>                 (c) <u>Coronary insufficiency</u> </td> <td style="vertical-align: top;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b><br/> <u>3 hrs 40 min</u> </td> </tr> <tr> <td colspan="3" style="vertical-align: top;"> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b> </td> </tr> </table> |  |  |  |  |  | <b>PART I. DEATH WAS CAUSED BY:</b><br><b>IMMEDIATE CAUSE (e)</b> <u>Congestive Heart failure</u><br><b>420.1</b> DUE TO<br><b>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.</b><br>(b) <u>Myocardial infarction</u><br>(c) <u>Coronary insufficiency</u> |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>3 hrs 40 min</u> | <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b> |  |  |
| <b>PART I. DEATH WAS CAUSED BY:</b><br><b>IMMEDIATE CAUSE (e)</b> <u>Congestive Heart failure</u><br><b>420.1</b> DUE TO<br><b>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.</b><br>(b) <u>Myocardial infarction</u><br>(c) <u>Coronary insufficiency</u>   |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>3 hrs 40 min</u>   |  |  |  |  |  |  |  |  |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b>   |  |  |  |  |  |  |  |  |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)<br><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br><b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <u>19</u><br><b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town)</b> (County) (State)   |  |  |  |  |  |  |  |  |  |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>13 Aug. 1961</u> , to <u>13 Aug. 1961</u> , that (I) (we) last saw the deceased alive on <u>13 Aug. 1961</u> , and that death occurred at <u>3:45</u> A.M., from the causes and on the date stated above.  |  |  |  |  |  |  |  |  |  |  |  |
| <b>22a. SIGNATURE</b><br><u>Charles Wong</u> M.D.  |  |  |  | <b>22b. DATE SIGNED</b><br><u>13 Aug 1961</u>  |  |  |  |  |  |  |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b><br><u>Raymond D. Ziska</u>   |  |  |  | <b>22d. ADDRESS</b><br><u>7722 Maple Ave, Takoma Park 12, Md</u>   |  |  |  |  |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Burial</u>  |  | <b>23b. DATE THEREOF</b><br><u>8/15/61</u>   |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Parklawn Cemetery</u>  |  |  |  |  |  |  |  |
| <b>23d. LOCATION (City, town or county)</b><br><u>Montgomery County, Maryland</u>  |  | <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Raymond D. Ziska</u> <u>Silver Spring, Maryland</u><br><u>Warner E. Pumphrey, Inc. 8434 Georgia Avenue</u>         |  |  |  |  |  |  |  |  |  |
| <b>25a. REC'D BY REGISTRAR</b><br><u>AUG 16 '61</u>  |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Arthur E. Hines</u>  |  |  |  |  |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificates be executed within 24 hours after death. The law requires that death certificates be executed within 24 hours after death. The law requires that death certificates be executed within 24 hours after death.

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Washington, D.C. 20540  
Department of the Interior  
Bureau of Land Management  
1011 North 1st Street  
June 13, 1961  
Dear Sir:  
Reference is made to your letter of June 1, 1961, regarding the proposed acquisition of certain land in the State of Alaska. The Bureau is currently reviewing the matter and will advise you of the results of its review as soon as possible.

Very truly yours,  
Director

Enclosure  
1011 North 1st Street  
June 13, 1961  
Bureau of Land Management  
Department of the Interior  
Washington, D.C. 20540

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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9379  
MONTGOMERY  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
09372

|   |                               |  |                                |
|---|-------------------------------|--|--------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Montgomery</i> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>MD.</i> b. COUNTY <i>Montgomery</i>                 |                                |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>  |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Boyds</i>  |                                |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>  |                               | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                |
| 3. NAME OF DECEASED (Type or print)<br>First <i>Lennie</i> Middle <i>R.</i> Last <i>Rose</i>  |                               | 4. DATE OF DEATH<br>Month <i>Aug.</i> Day <i>3</i> Year <i>1961</i>  |                                |
| 5. SEX <i>female</i>  | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>8/5/07</i> |
| 9. AGE (In years lost birthday) <i>53</i> yrs.  |                               | IF UNDER 1 YEAR<br>Months Days Hours Min.  | IF UNDER 24 HRS.               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY  |                                |
| 11. BIRTHPLACE (State or foreign country) <i>Kentucky</i>   |                               | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>   |                                |
| 13. FATHER'S NAME <i>Noah Farmer</i>  |                               | 14. MOTHER'S MAIDEN NAME <i>Annie Smallwood</i>  |                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>  |                               | 16. SOCIAL SECURITY NO. <i>none</i>  |                                |
| 17. INFORMANT <i>Claude Rose / same as Above.</i>   |                               | Address  |                                |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute hemorrhagic Pancreatitis</i><br><i>SB 7.0</i> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                               |  |                                |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19   |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |                                |
| 21. I certify that (I) (this hospital) attended the deceased from <i>8/2 1961</i> to <i>8/3 1961</i> , that (I) (we) last saw the deceased alive on <i>8/3 1961</i> , and that death occurred at <i>8 PM</i> , from the causes and on the date stated above.  |                               |  |                                |
| 22a. SIGNATURE <i>Robert G. Brewer</i>  |                               | 22b. DATE SIGNED   |                                |
| 22c. PHYSICIAN'S NAME (Type) <i>ROBERT G. BREWER</i>  |                               | 22d. ADDRESS <i>8218 Wisconsin Ave Beth</i>  |                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   |                               | 23b. DATE THEREOF <i>8/7/61</i>  |                                |
| 23c. NAME OF CEMETERY OR CREMATORY <i>Yellow Hill</i>   |                               | 23d. LOCATION (City, town, or county) (State) <i>Pike County, Kentucky</i>   |                                |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>Chin L. Mohaworth</i>   |                               | 24. ADDRESS <i>Damascus, Md.</i>   |                                |
| 25a. REC'D BY REGISTRAR   |                               | 25b. REGISTRAR'S SIGNATURE <i>Clifford S. Kincaid</i>  |                                |
| DATE <i>AUG 7 '61</i>   |                               |  |                                |

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FOR STATE  
HEALTH DEPT. (M)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

1  
MONTGOMERY STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9380 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09373

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)<br>a. STATE <u>Va</u> b. COUNTY <u>✓</u>                           |  |  |  |
| b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>  |  |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u>   |  |  |  |
| c. LENGTH OF STAY IN 1b <u>D.O.A.</u>  |  |  |  | d. STREET ADDRESS <u>1145 Murray Ave</u>   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bradley Blvd + Durbin Rd.</u>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Hiram Edward Rosenbaum</u>  |  |  |  | 4. DATE OF DEATH <u>Aug 2 1961</u>   |  |  |  |
| 5. SEX <u>male</u>   |  | 6. COLOR OR RACE <u>white</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>2-2-1911</u>                                 |  |
| 9. AGE (in years last birthday) <u>50</u> yrs.   |  | IF UNDER 1 YEAR Months Days  |  | IF UNDER 24 HRS. Hours Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>electrician</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>worked for contractors</u>  |  |  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Virginia</u>  |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>  |  |  |  |
| 13. FATHER'S NAME <u>Unknown</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Unknown</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WW 2</u>  |  |  |  | 16. SOCIAL SECURITY NO. <u>Unknown</u>   |  |  |  |
| 17. INFORMANT <u>Ruby Rosenbaum-Wife-same 2d</u>   |  |  |  | Address  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><u>420.1</u> IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                             |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.  |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>   |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  |  |  | 22b. DATE THEREOF <u>8/7/61</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Happy Valley Mem. Park</u> |  |
| 22d. LOCATION (City, town, or country) (State) <u>Elizabethton, Tennessee</u>  |  |  |  | 24a. REC'D BY REGISTRAR <u>DANUG 7 '61</u>   |  |  |  |
| 23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>   |  |  |  | 24b. REGISTRAR'S SIGNATURE <u>Bethesda, Maryland</u>   |  |  |  |

• <http://www.oxfordjournals.org/>



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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 09374

9381

|   |                                |  |   |
|---|--------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY MONTGOMERY MARYLAND  |                                | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE MARYLAND b. COUNTY MONTGOMERY                          |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA   |                                | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 45 BETHESDA   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9855 SINGLETON RD  |                                | d. STREET ADDRESS 1 9855 SINGLETON RD.   |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last ISRAEL A ROSENBLUM  |                                | 4. DATE OF DEATH Month August Day 5 Year 1961  |   |
| 5. SEX M  | 6. COLOR OR RACE W             | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH NOV. 2, 1911   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER-STORE   |                                | 10b. KIND OF BUSINESS OR INDUSTRY DRY CLEANING   | 9. AGE (In years last birthday) 49 yrs. IF UNDER 1 YEAR Months Days Hours Min.      |
| 11. BIRTHPLACE (State or foreign country) WASH DC   |                                | 12. CITIZEN OF WHAT COUNTRY? U.S.A   |   |
| 13. FATHER'S NAME MAX ROSENBLUM   |                                | 14. MOTHER'S MAIDEN NAME BLUME   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)  |                                | 16. SOCIAL SECURITY NO. —  |   |
| 17. INFORMANT MORRIS ACKERMAN   |                                | Address 7307 ASHBORO DR. CHCH.   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 420.1 CORONARY OCCLUSION<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE<br>DUE TO (c) 2 YEARS<br>DISEASE |                                |  | INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS   |                                |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Hour o. p. m. Month, Day, Year 19   |                                | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)              |
| 20f. (City or town) (County) (State)  |                                |  |   |
| 21. I certify that I attended the deceased from AUGUST, 1953, to AUGUST, 1961, that I last saw the deceased alive on AUGUST 3, 1961, and that death occurred at 605 M, from the causes and on the date stated above.  |                                |  |   |
| ACTUAL SIGNATURE Robert L. Krichmar   |                                | ADDRESS (Street, city or town, state) 7733 ALASKA AVENUE NW WASHINGTON 12 D.C. DATE SIGNED AUGUST 5 1961   |   |
| PHYSICIAN'S NAME (Type) ROBERT L. KRICHMAR  |                                |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL  | 22b. DATE THEREOF AUG. 6, 1961 | 22c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN  | 22d. LOCATION (City, town, or county) (State) FALLS CHURCH VA.                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE B. Dwyer   |                                | ADDRESS 3501-14 ST NW DATE AUG 9 '61   |   |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas   |                                |  |   |

CERTIFICATE OF DEATH

|  |  |  |  |   |  |                                       |  |   |  |
|--|--|--|--|---|--|---------------------------------------|--|---|--|
| 1. NAME OF DECEASED<br>JAMES H. HARRIS       |  | 2. SEX<br>Male                             |  | 3. AGE<br>65                                  |  | 4. DATE OF BIRTH<br>1888              |  | 5. PLACE OF BIRTH<br>New York             |  |
| 6. OCCUPATION<br>Teacher                     |  | 7. MARITAL STATUS<br>Married               |  | 8. DATE OF MARRIAGE<br>1915                   |  | 9. PLACE OF MARRIAGE<br>New York      |  | 10. NAME OF SPOUSE<br>Mary H. Harris      |  |
| 11. DATE OF DEATH<br>1953                    |  | 12. TIME OF DEATH<br>10:30 AM              |  | 13. PLACE OF DEATH<br>Home                    |  | 14. CAUSE OF DEATH<br>Heart Disease   |  | 15. MANNER OF DEATH<br>Natural            |  |
| 16. SIGNATURE OF DECEASED<br>James H. Harris |  | 17. SIGNATURE OF WITNESS<br>Mary H. Harris |  | 18. SIGNATURE OF PHYSICIAN<br>Dr. J. H. Smith |  | 19. SIGNATURE OF CLERK<br>J. H. Smith |  | 20. SIGNATURE OF REGISTRAR<br>J. H. Smith |  |

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

09375

9382

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Montgomery</b> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b><br>c. LENGTH OF STAY IN 1b <b>5 Days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>   |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Kentucky</b> <span style="float: right;">b. COUNTY <b>✓</b></span><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harlan</b><br>d. STREET ADDRESS <b>Browning, Apt. #17, Harlan Hospital</b> |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <b>Sergio Bastos Santos</b>   |  | <b>4. DATE OF DEATH</b><br>August 19, 1961   |  | e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |
| <b>5. SEX</b><br><b>Male</b>  |  | <b>6. COLOR OR RACE</b><br><b>White</b>  |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |
| <b>8. DATE OF BIRTH</b><br><b>January 18, 1960</b>  |  | <b>9. AGE</b> (In years last birthday) <b>1</b> yrs.   |  | IF UNDER 1 YEAR: Months _____ Days _____<br>IF UNDER 24 HRS.: Hours _____ Min. _____   |  |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Child</b>  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>None</b>  |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><b>Kentucky</b>  |  |  |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.A.</b>  |  |  |  |  |  |  |  |
| <b>13. FATHER'S NAME</b><br><b>Ottao A. Santos</b>  |  |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Suzanna B. Fausto</b>  |  |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) <b>NO</b>   |  | <b>16. SOCIAL SECURITY NO.</b><br><b>None</b>  |  | <b>17. INFORMANT</b> <b>The Medical Records</b><br><b>The Clinical Center, Bethesda, 14, Maryland</b>  |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive heart failure with pulmonary edema and</b><br>DUE TO (b) <b>Tetralogy of Fallot</b><br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) <b>Congenital</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>pulmonary artery</b><br><b>Postoperative Blalock anastomosis of right subclavian artery to right</b> |  |  |  |  |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)              |  |  |  |  |  |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  |  |  |
| <b>20f. (City or town)</b><br><b>August 14, 1961 to August 19, 1961</b>   |  | <b>20g. (County)</b><br><b>Harlan</b>  |  | <b>20h. (State)</b><br><b>Kentucky</b>   |  |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>August 19, 1961</b> <b>at</b> <b>11:00AM</b> <b>and that death occurred at</b> <b>11:00AM</b> <b>from the causes and on the date stated above.</b>  |  |  |  |  |  |  |  |
| <b>22a. SIGNATURE</b><br><b>THOMAS MERRIGAN, JR., M.D.</b>  |  |  |  | <b>22b. DATE SIGNED</b><br><b>8/19/61</b>  |  |  |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type) <b>THOMAS MERRIGAN, JR., M.D.</b>   |  |  |  | <b>22d. ADDRESS</b> <b>The Clinical Center, National Institutes Of Health, Bethesda 14, Md.</b>  |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><b>Burial</b>   |  | <b>23b. DATE THEREOF</b><br><b>Aug. 23, 1961</b>   |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>Rest Haven Cemetery</b>  |  |  |  |
| <b>23d. LOCATION</b> (City, town or county)<br><b>Harlan, Kentucky</b>  |  |  |  |  |  |  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>Robert G. Langhrey</b>  |  | <b>25a. REC'D BY REGISTRAR</b><br><b>AUG 22 '61</b>  |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><b>Arthur E. Hines</b>  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3850



to the 2000s

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

9383

09376

|  |  |   |  |  |  |   |   |
|--|--|---|--|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince Geo.</b>           |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>  |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>  |  |   |   |
| c. LENGTH OF STAY IN 1b  |  |   |  | d. STREET ADDRESS <b>952-East-West Hwy.</b>  |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shannon Nursing Home</b>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Angelo</b> Middle <b>J.</b> Last <b>Scandolos</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>Aug.</b> Day <b>11</b> Year <b>1961</b>   |  |   |   |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>March 25-1896</b>                                 |   |
| 9. AGE (In years lost birthday) <b>65</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>65</b> Days <b>65</b> Hours <b>65</b> Min.                                   |  | IF UNDER 24 HRS.<br>Months <b>65</b> Days <b>65</b> Hours <b>65</b> Min.   |  |   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Resturant Owner</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country) <b>Greece</b>               |   |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |   |  |  |  |   |   |
| 13. FATHER'S NAME <b>John Scandolos</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME <b>Helen Margelos</b>   |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>   |  |   |  | 16. SOCIAL SECURITY NO. <b>?</b>   |  | 17. INFORMANT Address <b>Nursing Home Records</b>                     |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Conjictive Heart failure</b><br>4431 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Heart Disease</b><br>DUE TO<br>(c) |  |   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 weeks</b>                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Oct 1958</b> to <b>Aug 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug 10 1961</b> , and that death occurred on <b>Aug 11 1961</b> , from the causes and on the date stated above.   |  |   |  |  |  |   |   |
| 22a. SIGNATURE <b>George Dickfield M.D.</b>  |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  | 22b. DATE SIGNED <b>8/11/61</b>                                       |   |
| 22c. PHYSICIAN'S NAME (Type) <b>HOWARD E. DICKFIELD</b>  |  |   |  | 22d. ADDRESS <b>6826 Regg's Pl. Hyattsville, Md.</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>  |  | 23b. DATE THEREOF <b>8/14/61</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>  |  | 23d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b> |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Company</b>   |  |   |  | 25a. REC'D BY REGISTRAR <b>2901 14th St. N.W. Washington 9, D.C.</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>                     |   |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2323

CELESTINE ORANGE

10000

Handwritten notes and stamps, including "CELESTINE ORANGE" and "10000".



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9384

09377

|   |   |  |  |   |   |
|---|---|--|--|---|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Montgomery</b> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b><br>c. LENGTH OF STAY IN 1b<br><b>29 Days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>The Clinical Center</b> |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, If institutions: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Takoma Park</b><br>d. STREET ADDRESS<br><b>716 Forston Drive</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <b>ALVIN VERNON SCHEIBLE</b>  |   |  | <b>4. DATE OF DEATH</b><br>Month <b>August</b> Day <b>3</b> Year <b>19 61</b>  |   |   |
| <b>5. SEX</b><br><b>Male</b>  | <b>6. COLOR OR RACE</b><br><b>White</b> | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><b>June 4, 1928</b>   |   | <b>9. AGE</b> (In years last birthday) <b>33</b> yrs.<br>IF UNDER 1 YEAR: Months _____ Days _____<br>IF UNDER 24 HRS.: Hours _____ Min. _____ |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>None</b>   |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>None</b>  |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><b>Virginia</b>                               |   |
| <b>13. FATHER'S NAME</b><br><b>Charles Scheible</b>   |   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Eldora King</b>  |   |   |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)   |   | <b>16. SOCIAL SECURITY NO.</b><br><b>None</b>  |  | <b>17. INFORMANT</b><br><b>The Medical Record</b><br><b>National Institutes of Health, Bethesda 14, Md.</b> |   |

|  |  |  |                            |   |                |
|--|--|--|----------------------------|---|----------------|
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Septicemia</b><br>DUE TO (b) <b>Acute lymphocytic leukemia</b><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>204.3</b> |  |  |                            | INTERVAL BETWEEN ONSET AND DEATH<br><b>36 hours</b><br><b>6 months</b>    |                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br><b>Mongolism</b>  |  |  |                            |   |                |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) |                            |   |                |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>   | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)                      | <b>20f. (City or town)</b> | <b>(County)</b>   | <b>(State)</b> |
| <b>21. I certify that (I) (this hospital) attended the deceased from July 5, 1961, to August 3, 1961 that (I) (we) last saw the deceased alive on August 3, 1961, and that death occurred at 7:00AM from the causes and on the date stated above.</b>  |  |  |                            |   |                |
| <b>22a. SIGNATURE</b><br><b>Geo. H. Porter III</b>   |  | <b>22b. DATE SIGNED</b><br><b>8/3/61</b>   |                            | <b>22c. PHYSICIAN'S NAME (Type)</b><br><b>GEORGE H. PORTER, III, M.D.</b> |                |
| <b>22d. ADDRESS</b><br><b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>  |  | <b>23a. LOCATION</b> (City, town or county) <b>D.C.</b>  |                            |   |                |
| <b>23b. DATE THEREOF</b><br><b>Aug 7-1961</b>  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>Prospect Hill</b>                                  |                            | <b>23d. LOCATION</b> (City, town or county) <b>D.C.</b>                   |                |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>Arthur J. Hall</b>   |  | <b>25a. REC'D BY REGISTRAR</b><br><b>DATE AUG 7 '61</b>  |                            | <b>25b. REGISTRAR'S SIGNATURE</b><br><b>Arthur J. Hall</b>                |                |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3332

(M)

Montgomery

Montgomery

Montgomery

Montgomery

Montgomery

Montgomery

The Clinical Center

The Clinical Center

ALVIN

ALVIN

ALVIN

ALVIN

Male

Male

Male

Male

None

None

None

None

Charles Schellie

Charles Schellie

The Medical Record

National Institute of Health, Bethesda, Md.

None

No

Leukemia

Leukemia

30 hours

3 hours

oncology

(1)

Geo. H. Porter III

DR. GEORGE H. PORTER, III, M.D.

Institute of Health

The Clinical Center, National

Institute of Health, Bethesda, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. Page 1 of this certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |   |   |   |  |  |   |  |  |  |  |
|---|--|---|--|---|---|---|---|--|--|---|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |   |  |   |   |   |   |  |  |   |  |  |  |  |
| 9385  |  |   |  |   |   |   |   |  |  |   |  |  |  |  |
| 09378   |  |   |  |   |   |   |   |  |  |   |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |  |   |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>DC</b> b. COUNTY <b>--</b> |   |   |  |  |   |  |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>  |  |   |  |   | c. LENGTH OF STAY IN 1b<br><b>--</b>  |   |   |  |  |   |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Bella Vista Nursing Home</b><br><b>571 University Blvd., East-Sixx</b>   |  |   |  |   | d. STREET ADDRESS<br><b>3724 New Hampshire Ave. N.W.</b>  |   |   |  |  |   |  |  |  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |   |   |   |  |  |   |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Alice L. Shadle</b>  |  |   |  |   | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>11</b> Year <b>19 61</b>   |   |   |  |  |   |  |  |  |  |
| 5. SEX<br><b>female</b>   |  | 6. COLOR OR RACE<br><b>white</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>11/21/1872</b>   |   | 9. AGE (In years last birthday)<br><b>88</b> yrs.  |  |   |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>At Home</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Ava, New York</b>   |   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  |  |   |  |  |  |  |
| 13. FATHER'S NAME<br><b>Unobtainable</b>  |  |   |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Unobtainable</b>   |   |   |  |  |   |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>   |  |   |  |   | 16. SOCIAL SECURITY NO. <b>no</b>   |   |   |  |  | 17. INFORMANT<br><b>Records at Nursing Home-- See #1</b>          |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>332X</b> IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis + Congestive Heart Failure</b><br>DUE TO (b) <b>Generalized arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |   |   |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs</b><br><b>8 yrs</b> |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                                    |   |   |  |  |   |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>a.m.</b> <b>19</b><br>p.m.   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town)<br><b>Prince Georges County, Md.</b>                          |   | 20g. (County)<br><b>Prince Georges County, Md.</b> |  |   |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>June 15, 1957</b> to <b>Aug 11, 1961</b> , that (I) (we) last saw the deceased alive on <b>8-11-1957</b> , and that death occurred <b>8:15 P.M.</b> from the causes and on the date stated above.  |  |   |  |   |   |   |   |  |  |   |  |  |  |  |
| 22a. SIGNATURE<br><b>Charles W. Harnsberger</b> M.D.  |  |   |  |   | 22b. DATE SIGNED<br><b>8-11-61</b>  |   |   |  |  |   |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>CHARS. W. HARNSDERGER</b>  |  |   |  |   | 22d. ADDRESS<br><b>4201 NEW HAMPSHIRE AVE N.W.</b>  |   |   |  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>8/15/61</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln Cemetery</b>  |   | 23d. LOCATION (City, town or county) (State)<br><b>Prince Georges County, Md.</b> |   |  |  |   |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>The S.H.Hines Co.</b>  |  |   |  |   | 25a. REC'D BY REGISTRAR<br><b>AUG 15 '61</b>  |   |   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hines</b>              |  |  |  |  |

2524

2250

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained to your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|---|--|--|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |   |  |   |  |   |  |  |  |   |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b>   |  | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda (Rural)</b> |  | c. LENGTH OF STAY IN 1b<br><b>DOA</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>District of Columbia</b> |  | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b>  |  | c. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>U. S. Naval Hospital</b>   |  |   |  |   |  | d. STREET ADDRESS<br><b>4701 Connecticut Ave. N.W. Apt 401</b>  |  |  |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Patricia McDermott Shirley</b>   |  | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>7</b> Year <b>19 61</b>                                      |  | 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>Caucasian</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>12 March 1936</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Washington, D. C.</b>                                     |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 9. AGE (In years last birthday)<br><b>25</b>   |  | IF UNDER 1 YEAR<br>Months <b>47</b> Days <b>X=3</b>   |  |
| 13. FATHER'S NAME<br><b>M. J. McDermott</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Rose Fuller</b>  |  |   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  |   |  |
| 16. SOCIAL SECURITY NO.   |  |   |  | 17. INFORMANT<br><b>John Arthur Shirley</b>   |  |   |  | Address<br><b>Same as #2 above</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage (spontaneous)</b><br>DUE TO (b) <b>2° to ruptured berry aneurysm.</b><br>DUE TO (c) <b>12 hrs</b>   |  |   |  |   |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hrs</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)               |  |   |  |  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)<br><b>Arlington</b>  |  | (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br><b>Frank J. Brochart</b>  |  |   |  | M.D.<br><b>Frank J. Brochart, M. D.</b>   |  |   |  | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  | DATE SIGNED<br><b>August 7, 1961</b>  |  |
| EXAMINER'S NAME (Type)  |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Joseph J. Brochart, Jr. LT(MC)USN</b>      |  |   |  | Address (Street, city, town, or county)  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>Aug. 10, 1961</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>   |  | 22d. LOCATION (City, town, or county)<br><b>Arlington Va.</b>   |  | (State)  |  |   |  |
| 23. FUNERAL DIRECTOR<br><b>Timothy Hanlon Funeral Home</b>  |  |   |  | ADDRESS<br><b>4745 Wisconsin Ave Washington, D. C.</b>  |  | 24a. REC'D BY REGISTRAR<br><b>AUG 10 '61</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hanna</b>   |  |   |  |

*Timothy Hanlon F.H. Wm. Bryson*



0882

(Rm 1)

U.S. Army Hospital

Medical Department

M. J. Kilmore

John S. Kilmore

John S. Kilmore

John S. Kilmore

John S. Kilmore

John S. Kilmore

John S. Kilmore

John S. Kilmore

John S. Kilmore

John S. Kilmore

John S. Kilmore

John S. Kilmore

John S. Kilmore

John S. Kilmore



9387

## CERTIFICATE OF DEATH

Reg. Dist. No.

09380

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Spring</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>2309 Seibel Drive</b>   |  | d. STREET ADDRESS<br><b>2309 Seibel Drive</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Sadie</b> Middle <b>Agnes</b> Last <b>Smith</b>  |  | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>13th</b> Year <b>1961</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 6th 1890</b>   |
| 9. AGE (In years last birthday)<br><b>71</b> yrs.  |  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Prince Geo. Co. Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>Richard A Windsor,</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Rose H. Hutchin</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |   |
| 17. INFORMANT<br><b>Earl L. Smith</b>  |  | Address<br><b>2309 Seibel Dr. S.S. Md.</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b><br><b>450.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b><br>DUE TO (c) <b>Endometriosis</b> |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 yrs.</b><br><b>12 yrs.</b><br><b>10 yrs.</b> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>May 22, 1961</b> to <b>August 13, 1961</b> , that I last saw the deceased alive on <b>8-13-61</b> , and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above.   |  |  |   |
| ACTUAL SIGNATURE<br><b>Joseph H. Doughlin</b> M.D.   |  | ADDRESS (Street, city or town, state)<br><b>934 Ellsworth Dr. Silver Spring, Md.</b>   |   |
| DATE SIGNED<br><b>8-13-61</b>  |  |  |   |
| PHYSICIAN'S NAME (Type)<br><b>W. W. Chambers, Co.</b>  |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>8/15/61</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Epiphany Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Forestville Maryland.</b>         |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. W. Chambers, Co.</b>   |  | 24a. ADDRESS OF REGISTRAR<br><b>5801 Cleveland Ave. Riverdale, Md.</b>   |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hanks</b>   |  | DATE<br><b>8-13-61</b>   |   |

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1728

Robert H. Boyer

9076

Figure 1. Example

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. The certificate should be executed by the medical examiner, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Item 18 Film 293 8-18-61 ams

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9388 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09381

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>MONTGOMERY</b>  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>D.C.</b><br>b. COUNTY<br><b>WASHINGTON</b>                  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BETHESDA</b>  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>WASHINGTON</b>   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>SUBURBAN</b>  |  |  | d. STREET ADDRESS<br><b>1301 15th. St. N.W.</b>   |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>LYNN L. SOUTTER</b>   |  |  | 6. DATE OF DEATH<br><b>AUG. 9 19 61</b>   |  |  |
| 5. SEX<br><b>Female</b>  |  |  | 7. MARIED<br><input type="checkbox"/> NEVER MARRIED<br><input type="checkbox"/> WIDOWED<br><input type="checkbox"/> DIVORCED<br><input checked="" type="checkbox"/> |  |  |
| 6. COLOR OR RACE<br><b>White</b>   |  |  | 8. DATE OF BIRTH<br><b>July 28 1908</b>   |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Advertising Business</b>   |  |  | 9. AGE (in years last birthday)<br><b>53</b>  |  |  |
| 10b. KIND OF BUSINESS OR INDUSTRY  |  |  | 11. BIRTHPLACE (State or foreign country)<br><b>D.C.</b>  |  |  |
| 13. FATHER'S NAME<br><b>EDGAR SOUTTER</b>  |  |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>LILLIE LYNN</b>  |  |  |
| 16. SOCIAL SECURITY NO.<br><b>057-10-9284</b>  |  |  | 17. INFORMANT<br><b>Mrs. Paul Snaver</b>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per Part I (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Aspiration of Gastric contents</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Intestinal obstruction</b><br>DUE TO<br>(c) <b>Carcinoma of rectum</b>  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b>   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  | 20f. (City or town)<br>(County)<br>(State)  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |   |  |  |
| ACTUAL SIGNATURE<br><b>Frank J. Brochart</b>   |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  |
| EXAMINER'S NAME (Type)<br><b>Frank J. Brochart</b>   |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial-transit</b>   |  |  | 22b. DATE THEREOF<br><b>8-9-61</b>  |  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Dumfries Cemetery</b>   |  |  | 22d. LOCATION (City, town, or country)<br><b>Dumfries, Virginia</b>   |  |  |
| 23. FUNERAL DIRECTOR<br><b>ROBERT A. PUMPHREY</b>  |  |  | 24a. REC'D BY REGISTRAR<br><b>AUG 14 '61</b>  |  |  |
| ADDRESS<br><b>Bethesda, Md.</b>  |  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Frank</b>  |  |  |

02121

2338



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9389

09382

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Ohio</b><br>b. COUNTY <b>Dayton</b>  |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>24 Days</b>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>The Clinical Center</b>   |  |   |  | d. STREET ADDRESS<br><b>1314 Harvard Boulevard</b>   |  |   |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br><b>WILLIAM WAITT SPURGEON</b>   |  |   |  | <b>4. DATE OF DEATH</b><br>Month <b>August</b> Day <b>4</b> Year <b>1961</b>   |  |   |  |
| <b>5. SEX</b><br><b>Male</b>   |  | <b>6. COLOR OR RACE</b><br><b>White</b>   |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | <b>8. DATE OF BIRTH</b><br><b>July 17, 1898</b>                                     |  |
| <b>9. AGE</b> (In years last birthday)<br><b>63</b> yrs.   |  | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Circulation Manager</b> |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>Newspaper</b>   |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><b>North Carolina</b> |  |
| <b>13. FATHER'S NAME</b><br><b>John S. Spurgeon</b>  |  |   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Carrie Waitt</b>   |  |   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) <b>Yes</b> <b>WW I</b>   |  |   |  | <b>17. INFORMANT</b> <b>The Medical Record</b>   |  |   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic bronchogenic carcinoma</b><br>162.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/><br>INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b> |  |   |  | <b>21. I certify that (I) (this hospital) attended the deceased from July 11, 1961 to August 4, 1961 that (I) (we) last saw the deceased alive on August 4, 1961, and that death occurred at 1:15 PM from the causes and on the date stated above.</b> |  |   |  |
| <b>22a. SIGNATURE</b><br><b>Robert H. Levin</b>  |  |   |  | <b>22b. DATE SIGNED</b><br><b>8/4/61</b>   |  |   |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b><br><b>ROBERT H. LEVIN, M.D.</b>  |  |   |  | <b>22d. ADDRESS</b><br><b>The Clinical Center, National Institutes of Health, Bethesda 11, Maryland</b>  |  |   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><b>Removal-Burial</b>  |  | <b>23b. DATE THEREOF</b><br><b>18/6/1961</b>  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>College Park Cemetery</b>  |  | <b>23d. LOCATION</b> (City, town or county) (State)<br><b>East Point, Georgia</b>   |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>James Lawrence Lewis Jr.</b>   |  |   |  | <b>25a. REC'D BY REGISTRAR</b><br><b>AUG 8 '61</b>   |  |   |  |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><b>Arthur S. Kincaid</b>  |  |   |  |  |  |   |  |

8228

8228

(M)

Montgomery

Ohio

Bellevue

St. Louis

St. Louis

The Clinical Center

The Clinical Center

of

August

STUDY

WALL

WALL

x

62

July 12, 1962

White

Male

121

North Carolina

Manager

Organization Manager

Garfield Hotel

John F. Spurgeon

The Medical Record

Not available National Institutes of Health, Bethesda, Md.

Yes

Yes

2 months

Statistical photo-ortho correlation

(1)

July 12, 1962

July 12, 1962

August 12, 62

121

The Clinical Center, National Institutes of Health, Bethesda, Md.

ROBERT H. LARSEN, M.D.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9390

CERTIFICATE OF DEATH

09383

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Dist. of Col.</u> b. COUNTY <u>47X</u> |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington DC</u>                                       |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Restmor Sanitarium</u>   |  | d. STREET ADDRESS <u>1410 M. St. N.W.</u>   |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>ANNIE L Stephens</u>   |  | 4. DATE OF DEATH <u>Aug 27 1961</u>   |  |
| 5. SEX <u>female</u>   |  | 6. COLOR OR RACE <u>White</u>   |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <u>Dec 7 1876</u>  |  |
| 9. AGE (In years) <u>84</u> yrs. Months Days Hours Min.  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>                                   |  |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>Secy US govt.</u>   |  | 11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>   |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  | 13. FATHER'S NAME <u>WILBUR Stephens</u>  |  |
| 14. MOTHER'S MAIDEN NAME <u>LEAVERTON</u>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   |  |
| 16. SOCIAL SECURITY NO. <u>none</u>  |  | 17. INFORMANT <u>WINIFRED M HAGER</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Terminal broncho pneumonia</u><br>DUE TO (b) <u>Cardiovascular disease</u><br>DUE TO (c) <u>4221</u>   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3da</u><br><u>4yrs.</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                                      |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 49</u> to <u>Aug 27</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Aug 27</u> , 19 <u>61</u> , and that death occurred at <u>8 P.</u> M, from the causes and on the date stated above. |  |   |  |
| 22a. SIGNATURE <u>W. H. Quayle</u>   |  | 22b. DATE SIGNED <u>8-27-61</u>   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>W. H. Quayle M.D.</u>  |  | 22d. ADDRESS <u>1822 Biltmore St. N.W. Washington DC</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>8-28-61</u>   |  | 23b. DATE THEREOF <u>Rec'd</u>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Restmor</u>  |  | 23d. LOCATION (City, town or county) (State) <u>Washington DC</u>   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>   |  | 24a. REC'D BY REGISTRAR <u>AUG 29 1961</u>  |  |
| ADDRESS <u>at Buchanan</u>   |  | 24b. REGISTRAR'S SIGNATURE <u>P. J. ...</u>   |  |

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9391

## CERTIFICATE OF DEATH

Reg. Dist. No. 119384

|  |                               |  |  |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>  |                               | c. LENGTH OF STAY IN 1b<br><u>SILVER SPRING</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9006 LINTON ST</u>   |                               | d. STREET ADDRESS <u>19006 LINTON ST</u>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>LINA</u> Middle <u>STERN</u> Last <u>STERN</u>   |                               | 4. DATE OF DEATH<br>Month <u>AUG.</u> Day <u>20</u> Year <u>1961</u>   |  |
| 5. SEX <u>FEMALE</u>   | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>SEPT. 29, 1888</u> |
| 9. AGE (In years last birthday) <u>72</u> yrs.   |                               | 10. IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BABY SITTER</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>   |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>  |  |
| 13. FATHER'S NAME <u>ABRAHAM GOLDSCHMIDT</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>BETTY KLEEBLATT</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>   |                               | 16. SOCIAL SECURITY NO. <u>088-20-1868</u>   |  |
| 17. INFORMANT <u>MRS LISELOTT FEFERMAN</u>   |                               | Address <u>S.S. Md. 9006 LINTON ST</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary artery insufficiency</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery atherosclerosis</u> DUE TO (c) <u>Unknown</u> |                               | INTERVAL BETWEEN ONSET AND DEATH <u>10 to 15 minutes</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of right ovary with metastasis</u>  |                               |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>                          |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>August 13, 1961</u> to <u>August 20, 1961</u> , that I last saw the deceased alive on <u>August 13, 1961</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.   |                               |  |  |
| ACTUAL SIGNATURE <u>Claron H. Traum</u> M.D.   |                               | ADDRESS (Street, city or town, state) <u>8237-Georgia Ave. Annapolis Md.</u>   |  |
| PHYSICIAN'S NAME (Type) <u>ARON H. TRAUM, MD.</u>  |                               | DATE SIGNED <u>Aug 20 61</u>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |                               | 22b. DATE THEREOF <u>AUG. 21, 1961</u>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASHINGTON CEMETERY</u>   |                               | 22d. LOCATION (City, town, or county) (State) <u>HYATTSVILLE Md.</u>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Dougherty &amp; Sons</u>  |                               | ADDRESS <u>3501-14 St NW</u>   |  |
| 24a. REC'D BY REGISTRAR <u>AUG 24 61</u>   |                               | 24b. REGISTRAR'S SIGNATURE <u>Robert A. Trautman</u>   |  |

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9392

CERTIFICATE OF DEATH

115385

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Montgomery</b> MARYLAND  |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>            |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |  |   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |  |   |  |
| c. LENGTH OF STAY IN 1b   |  |   |  | d. STREET ADDRESS<br><b>5300 Westbard Avenue</b>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>5300 Westbard Avenue</b>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <b>HENRY</b> Middle <b>J.</b> Last <b>STERZER</b>   |  |   |  | <b>4. DATE OF DEATH</b><br>Month <b>August</b> Day <b>1</b> Year <b>1961</b>  |  |   |  |
| <b>5. SEX</b><br><b>Male</b>  |  | <b>6. COLOR OR RACE</b><br><b>White</b>   |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | <b>8. DATE OF BIRTH</b><br><b>Aug. 27, 1890</b>                                 |  |
| <b>9. AGE</b> (In years last birthday) <b>70</b> yrs.   |  | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Ret.-Wholesaler</b> |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><b>Washington, D. C.</b>  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>USA</b>                               |  |
| <b>13. FATHER'S NAME</b><br><b>John N. Sterzer</b>  |  |   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Alma Rupel</b>  |  |   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service)<br><b>No</b>   |  |   |  | <b>16. SOCIAL SECURITY NO.</b><br><b>None</b>   |  |   |  |
| <b>17. INFORMANT</b><br><b>Elsie W. Sterzer-Wife-same 2d</b>  |  |   |  | <b>Address</b>  |  |   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line, or (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (e)<br><b>420.0</b> DUE TO <b>Arteriosclerotic Heart Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO <b>Bronchopneumonia connected w/</b><br><b>Chronic Pulmonary Emphysema</b> |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 YRS.</b>   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br><b>Bronchopneumonia Chronic Pulmonary Emphysema</b>  |  |   |  | <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>  |  |   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II at item 18)  |  |   |  |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour e.m. p.m.<br><b>19</b>   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>            |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  | <b>20f. (City or town)</b> (County) (State)                                     |  |
| <b>21. I certify that (I) (his hospital) attended the deceased from July 29, 1961, to August 1, 1961, that (I) (we) last saw the deceased alive on July 29, 1961, and that death occurred at 2:30 P.M., from the causes and on the date stated above.</b>   |  |   |  |   |  |   |  |
| <b>22e. SIGNATURE</b><br><b>Henry C. Scruggs</b>  |  |   |  | <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>            |  | <b>22b. DATE SIGNED</b>   |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><b>HENRY C. SCRUGGS</b>  |  |   |  | <b>22d. ADDRESS</b><br><b>7720 Leveeview Ave Bethesda Md.</b>   |  |   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><b>Burial</b>   |  | <b>23b. DATE THEREOF</b><br><b>8/4/61</b>   |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>Rock Creek Cemetery</b>   |  | <b>23d. LOCATION</b> (City, town or county) (State)<br><b>Washington, D. C.</b> |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>Robert A. Pumphrey</b>  |  |   |  | <b>ADDRESS</b><br><b>Bethesda, Maryland</b>   |  | <b>25a. REC'D BY REGISTRAR</b><br><b>AUG 4 '61</b>                              |  |
|   |  |   |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><i>Arthur L. Hanna</i>   |  |   |  |

(M)

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Maryland

Bethesda

5300 Westford Avenue

Aug. 27, 1930

Washington, D. C.

Alma Kugel

Plate W. Stearns-Elizanne 24

Washington, D. C.

Rock Creek Cemetery

Bethesda, Maryland

Burial

Robert A. Humphrey



TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09386

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|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Montgomery</i> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)<br>a. STATE <i>md</i> b. COUNTY <i>Montgomery</i>                  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sakoma Park</i>   |  |  |  | c. LENGTH OF STAY IN 1b <i>10 years</i>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8001 Barron arc.</i>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED (Type or print) First <i>MORRIS</i> Middle <i>L</i> Last <i>STIER</i>   |  |  |  | 4. DATE OF DEATH Month <i>August</i> Day <i>25</i> Year <i>1961</i>  |  |   |  |
| 5. SEX <i>Male</i>  |  | 6. COLOR OR RACE <i>White</i>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <i>March 15, 1874</i>  |  |
| 9. AGE (in years lost birthday) <i>87</i> yrs.  |  | IF UNDER 1 YEAR Months Days Hours Min. |  | IF UNDER 24 HRS.   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Teacher</i>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <i>Public Schools</i>  |  | 11. BIRTHPLACE (State or foreign country) <i>Md.</i>                            |  |
| 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>  |  |  |  |  |  |   |  |
| 13. FATHER'S NAME <i>John N. Stier</i>  |  |  |  | 14. MOTHER'S MAIDEN NAME <i>China Shipley</i>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>-</i>   |  |  |  | 16. SOCIAL SECURITY NO. <i>-</i>   |  | 17. INFORMANT <i>Mr. Howard Stier</i> Address <i>Above</i>                      |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>Congestive heart failure</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) <i>many years</i> |  |  |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>   |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)          |  |
|   |  |  |  | 20f. (City or town) (County) (State)   |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <i>December 19 58</i> to <i>Aug 24, 1961</i> , that (I) (we) last saw the deceased alive on <i>Aug 24 1961</i> , and that death occurred at <i>6:30 AM</i> , from the causes and on the date stated above.  |  |  |  |  |  |   |  |
| 22a. SIGNATURE <i>James R. Coleman MD.</i> M.D.   |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  | 22b. DATE SIGNED <i>8/25/61</i>   |  |
| 22c. PHYSICIAN'S NAME (Type) <i>JAMES R. COLEMAN</i>  |  |  |  | 22d. ADDRESS <i>7335 Shige Ave., Silver Spring, Md.</i>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   |  | 23b. DATE THEREOF <i>8-28-61</i>       |  | 23c. NAME OF CEMETERY OR CREMATORY <i>McKendree</i>  |  | 23d. LOCATION (City, town, or county) (State) <i>Parkville, Howard Co., Md.</i> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur A. Haight</i> ADDRESS <i>Parkville, Md.</i>  |  |  |  | 25a. REC'D BY REGISTRAR DATE <i>AUG 29 '61</i>   |  | 25b. REGISTRAR'S SIGNATURE <i>Charles E. Hunt</i>                               |  |

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DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
STATE OF NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9394

CERTIFICATE OF DEATH

Item 2 Film G295 8/29/61 iwk

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|   |  |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br>Montgomery  |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Bethesda (Rural) |  | c. LENGTH OF STAY IN lb<br>174 days  |  | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)<br>a. STATE<br>Maryland  |  | b. COUNTY<br>Montgomery   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>U. S. Naval Hospital  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  | f. STREET ADDRESS<br>Bethesda  |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>Allen  |  | 4. DATE OF DEATH<br>August 20 1961   |  | 5. SEX<br>Male   |  | 6. COLOR OR RACE<br>Caucasian  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH<br>9-22-25   |  | 9. AGE (In years last birthday)<br>35 yrs.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Armed Forces   |  | 11. BIRTHPLACE (County & State, or foreign country)<br>W. Virginia   |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 13. FATHER'S NAME<br>Fred D. Stissel  |  | 14. MOTHER'S MAIDEN NAME<br>Sadie Chafin   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br>Yes WW II   |  | 16. SOCIAL SECURITY NO.<br>8236-36-9095  |  | 17. INFORMANT<br>Hospital Records   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 197.3<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) PULMONARY METASTASES<br>(c) RHABDOMYO SARCOMA LEFT THIGH |  | INTERVAL BETWEEN ONSET AND DEATH   |  | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>RADIATION PNEUMONITIS |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)         |  | 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br>19   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |
| 20f. (City or town)   |  | (County)   |  | (State)  |  | 21. I certify that (1) (this hospital) attended the deceased from February 27, 1961 to August 20, 1961, that (2) (we) last saw the deceased alive on August 20, 1961, and that death occurred at 11:45 PM, from the causes and on the date stated above. |  |   |  |
| 22a. SIGNATURE<br>W. J. Mullins Jr.   |  | M.D.   |  | 22b. DATE SIGNED<br>21 August 1961   |  | 22c. PHYSICIAN'S NAME (Type)<br>W. J. MULLINS, JR. LT MC USN   |  | 22d. ADDRESS<br>U. S. Naval Hospital, Bethesda, Md.   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial - Shippment 22 Aug 1961   |  | 23b. DATE THEREOF<br>22 Aug 1961   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Family Cemetery  |  | 23d. LOCATION (City, town or county)<br>New Town   |  | (State)<br>W. Va.   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br>W.W. Chambers, 1400 Chapin St. Washington, D.C.   |  | 25a. REC'D BY REGISTRAR<br>DATE AUG 24 '61   |  | 25b. REGISTRAR'S SIGNATURE<br>Arthur L. Kross  |  |  |  |   |  |

*Mythology*

(M)

PULMONARY METASTASES  
RHABDOMYOSARCOMA LEFT THIGH

RADIATION FIBROSITIS

*W. J. Mulline*

W. J. Mulline, M.D., 1400 Chapin St., Washington, D.C.  
U.S. Naval Hospital, Bethesda, Md.

9395

CERTIFICATE OF DEATH

Reg. Dist. No. 09388

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MONTANA</b> b. COUNTY <b>NE</b> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>      |  | c. LENGTH OF STAY IN 1b<br><b>five weeks</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Suburban Hospital</b> |  | d. STREET ADDRESS<br><b>63X-3</b>  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |  |  |  |

|   |                                  |   |   |  |   |
|---|----------------------------------|---|---|--|---|
| 3. NAME OF DECEASED (Type or print)<br><b>Lou</b>   |                                  | First Middle Last<br><b>Stringfellow</b>  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>August 3, 19 61</b>               |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 13, 1871</b> |  | 9. AGE (In years last birthday)<br><b>90</b> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b> |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>own Home</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Three Rivers, Michigan</b> |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                  |   |   |  |   |

|   |  |  |  |
|---|--|--|--|
| 13. FATHER'S NAME<br><b>Unknown Peek</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Almira Dimick</b> |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b> |  | 16. SOCIAL SECURITY NO.<br><b>None</b>           |  |
| 17. ADDRESS<br><b>Silver Spring, Maryland</b>                                   |  |  |  |
| 18. ADDRESS<br><b>Mrs. Virginia L. Bruner, 1108 Highland Drive</b>              |  |  |  |

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b><br>DUE TO <b>422.1</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Arteriosclerosis</b><br>DUE TO<br>(c) |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5-10 yrs</b><br><b>?</b> |  |
|---|--|---|--|

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>metastatic Carcinoma of lungs (primary site unknown)</b> |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br>19   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |  |
| 20f. (City or town)  |  | (County)  |  | (State)   |  |

|   |  |
|---|--|
| 21. I certify that I attended the deceased from <b>19 58</b> to <b>3 Aug</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>2 Aug</b> , 19 <b>61</b> , and that death occurred at <b>4:30 A</b> M, from the causes and on the date stated above. |  |
| ACTUAL SIGNATURE<br><b>William D. Aud</b>   | ADDRESS (Street, city or town, state)<br><b>9086 Coleville Rd Silver Spring Md</b> |
| PHYSICIAN'S NAME (Type)<br><b>WILLIAM D. AUD</b>  | DATE SIGNED<br><b>8/13/61</b>  |

|   |  |                   |  |   |  |   |  |
|---|--|-------------------|--|---|--|---|--|
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial/Transit 8/7/61</b> |  | 22b. DATE THEREOF |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Forest Lawn Cemetery</b> |  | 22d. LOCATION (City, town, or county) (State)<br><b>Glendale California</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Warner E. Pumphrey, Inc.</b>       |  |                   |  | ADDRESS<br><b>8434 Georgia Avenue</b>                             |  | 24a. REC'D BY REGISTRAR<br>DATE <b>AUG 7 '61</b>                            |  |
|   |  |                   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>              |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1932

NAME OF DECEASED

AGE

DATE OF DEATH

Five years

Female

Deceased

Low

Deceased

Female

May 12, 1932

Three days, Monday

One hour

Deceased

Child's death

Deceased

Mr. Thomas L. Smith, 1100 Fifth Street, N.W., Washington, D.C.

None

No

*Charles L. Smith*  
*Deceased*

*Deceased (Living of the deceased)*

*Deceased (Living of the deceased)*

*Deceased (Living of the deceased)*

Deceased

Deceased

Deceased

Deceased



1  
FOR STATE  
HEALTH DEPT.

MD  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9396 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09389

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>            |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>At Takoma Park</u> <u>D.O.A.</u>  |  |  |  | c. LENGTH OF STAY in 1b  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San. &amp; Hosp.</u>   |  |  |  | d. STREET ADDRESS <u>Silver Spring</u> <u>10407 Berry Street</u>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>William Tyler Stultz</u>   |  |  |  | 4. DATE OF DEATH <u>Aug 3 1961</u>   |  |  |  |
| 5. SEX <u>Male</u>  |  | 6. COLOR OR RACE <u>White</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 8. DATE OF BIRTH <u>8-11-11</u>  |  |
| 9. AGE (In years last birthday) <u>50 1/2</u>   |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.   |  | a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bar Tender &amp; Care taker.</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 11. BIRTHPLACE (State or foreign country) <u>N.C.</u>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |  |  |
| 13. FATHER'S NAME <u>William Stultz</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Cora Watts Ward</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |  |  |  | 16. SOCIAL SECURITY NO. <u>238-14-2466</u>   |  |  |  |
| 17. INFORMANT <u>Mr. Tyler F Stultz</u>   |  |  |  | Address <u>1602 Gridley La SS md.</u>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u><br>DUE TO (b) <u>CORONARY SCLEROSIS AND OCCLUSION, OLD</u> MONTHS<br>DUE TO (c) <u>ASPIRATION OF GASTRIC CONTENT</u> MINUTES.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIED IN AUTOMOBILE WHILE DRIVING</u> |  |  |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)           |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.   |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |
| EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>  |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |
|   |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |  |  |
|   |  |  |  | Address (Street, city, town, or county) <u>8-3-61</u>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 22b. DATE THEREOF  |  | 22c. NAME OF CEMETERY OR CREMATORY   |  | 22d. LOCATION (City, town, or county)  |  |
| <u>Burial-Transit 8/5/61</u>  |  | <u>8/5/61</u>  |  | <u>Thursjay Church Cemetery</u>  |  | <u>Stokes County, Madison North</u>  |  |
| 23. FUNERAL DIRECTOR <u>Raymond A. Ziska</u>  |  |  |  | 24a. REC'D BY REGISTRAR  |  |  |  |
| <u>Warner E. Pumphrey, Inc.</u>   |  |  |  | 24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>   |  |  |  |
| VS. A15ME 5M 9/60   |  |  |  | DATE <u>Aug 9 '61</u>  |  |  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

02820

02820

M

STREET E. HENRIOT, INC. 1001 CENTRAL AVENUE  
ALBANY, N.Y. 12206  
ALBANY, N.Y. 12206

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

M

| 1. PLACE OF DEATH   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)          |  |  |  |
|---|--|--|--|--|--|--|--|
| a. COUNTY   |  |  |  | a. STATE   |  |  |  |
| Montgomery  |  |  |  | Maryland   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |  |  |  | b. COUNTY  |  |  |  |
| Takoma Park   |  |  |  | Montgomery   |  |  |  |
| c. LENGTH OF STAY IN 1b   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)               |  |  |  |
| 1 day   |  |  |  | Silver Spring 22   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  |  |  |  | d. STREET ADDRESS  |  |  |  |
| Washington Sanitarium + Hospital  |  |  |  | 90 23 Flower Avenue  |  |  |  |
| 3. NAME OF DECEASED (Type or print)   |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| Lucemma Forest Tallman  |  |  |  | 8 - 31 - 1961  |  |  |  |
| 5. SEX  |  |  |  | 6. COLOR OR RACE   |  |  |  |
| Female  |  |  |  | White  |  |  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>  |  |  |  | 8. DATE OF BIRTH   |  |  |  |
| WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  | 9 - 15 - 77 83   |  |  |  |
| 9. AGE (In years last birthday)   |  |  |  | IF UNDER 1 YEAR  |  |  |  |
| 83 yrs.   |  |  |  | Months Days Hours Min.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| Housewife   |  |  |  | West Virginia  |  |  |  |
| 13. FATHER'S NAME   |  |  |  | 14. MOTHER'S MAIDEN NAME   |  |  |  |
| Marshall G. Drake   |  |  |  | Elizabeth McQuain  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |  |  | 16. SOCIAL SECURITY NO.  |  |  |  |
| (If yes give war or dates of service)   |  |  |  | Hospital Records   |  |  |  |
| 17. INFORMANT   |  |  |  | Address  |  |  |  |
| Hospital Records  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause and line for (a), (b), and (c))  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  |  |  |  | 8/11/61  |  |  |  |
| 260X DUE TO   |  |  |  | 4/11/60  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  | 34 yrs.  |  |  |  |
| (b) Diabetes Mellitus   |  |  |  |  |  |  |  |
| (c) Chr. Deg. Degenerative & Hypertension   |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)    |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year  |  |  |  | 20d. INJURY OCCURRED   |  |  |  |
| Hour a.m. p.m.  |  |  |  | While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>              |  |  |  |
| 19  |  |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                         |  |  |  |
|   |  |  |  | 20f. (City or town) (County) (State)   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from 8/30/61 to 8/30/61, that (I) (we) last saw the deceased alive on 8/30/61, and that death occurred at 7:45 PM, from the causes and on the date stated above. |  |  |  |  |  |  |  |
| 22a. SIGNATURE  |  |  |  | 22b. DATE SIGNED   |  |  |  |
| Howard I. Mowse   |  |  |  |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)  |  |  |  | 22d. ADDRESS   |  |  |  |
|   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  |  | 23b. DATE THEREOF  |  |  |  |
| Burial  |  |  |  | Sept 4 - 61  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  |  |  | 23d. LOCATION (City, town or county) (State)   |  |  |  |
| Pleasant Ridge  |  |  |  | Rockwood. Tenn.  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE  |  |  |  | 25a. REC'D BY REGISTRAR  |  |  |  |
| Arthur Walters  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |
| 254 Carroll St. N.W. - Wash. D.C.   |  |  |  | C. J. S. Kline   |  |  |  |
| DATE SEP 5 '61  |  |  |  |  |  |  |  |

1930

1930

(M)

Montgomery

Montgomery

2/18/30

2/18/30

3 - 1 - 8

Washington + Hospital

Forest Tallon

Lucania

9-12-30

Female White

West Virginia

Forest

Eligible for

Marshall B. Dyke

Hospital Records

(T)

2/18/30

2/18/30

1930

X

Forest Tallon

2/18/30

2/18/30

2/18/30

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                               |                                 |   |  |   |  |   |  |   |  |
|---|--|-------------------------------|---------------------------------|---|--|---|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                               |                                 |   |  |   |  |   |  |   |  |
| 9398 CERTIFICATE OF DEATH 09391   |  |                               |                                 |   |  |   |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>  |  |                               |                                 |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> |  |   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney, Md.</u>  |  |                               |                                 |   |  | c. LENGTH OF STAY IN 1b <u>6 days</u>   |  |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General Hospital</u>   |  |                               |                                 |   |  | d. STREET ADDRESS <u>425 N. Frederick Dr.</u>   |  |   |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>Leon Albert Tarbox</u>   |  |                               |                                 |   |  | 4. DATE OF DEATH <u>August 31 1961</u>  |  |   |  |   |  |
| 5. SEX <u>Male</u>  |  | 6. COLOR OR RACE <u>White</u> |                                 | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>5-26-1899</u>   |  | 9. AGE (In years last birthday) <u>62 yrs.</u>                              |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>   |  |                               |                                 |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>AEC</u>  |  | 11. BIRTHPLACE (County & State, or foreign country) <u>Warren, Penna.</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>  |  |
| 13. FATHER'S NAME <u>Philip Sheridan Tarbox</u>   |  |                               |                                 |   |  | 14. MOTHER'S MAIDEN NAME <u>Grace Phillips</u>  |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |  |                               |                                 | 16. SOCIAL SECURITY NO. <u>Unknown</u>  |  | 17. INFORMANT <u>Hospital records</u>   |  |   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  |  |                               |                                 |   |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u>   |  |                               |                                 |   |  |   |  |   |  | <u>One year</u>   |  |
| DUE TO (b) <u>OBSTRUCTIVE PULMONARY EMPHYSEMA</u>   |  |                               |                                 |   |  |   |  |   |  | <u>20 years</u>   |  |
| DUE TO (c) <u>ARTERIOSELENOTIC HEART DISEASE</u>  |  |                               |                                 |   |  |   |  |   |  | <u>20 years</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC RENAL INSUFFICIENCY - PEPTIC ULCER</u>   |  |                               |                                 |   |  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                               |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Hour a.m. p.m.   |  | Month, Day, Year<br>19        |                                 | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                                     |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)   |  | (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7:00 P.M.</u> 19 <u>59</u> to <u>SEPT 1, 1961</u> , that (I) (we) last saw the deceased alive on <u>AUGUST 31, 1961</u> , and that death occurred at <u>12:50 P.M.</u> from the causes and on the date stated above. |  |                               |                                 |   |  |   |  |   |  |   |  |
| 22a. SIGNATURE <u>Gordon S. Rosenberger</u>   |  |                               |                                 |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>               |  | 22b. DATE SIGNED <u>Aug 31, 1961</u>  |  |   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Gordon S. Rosenberger</u>   |  |                               |                                 |   |  | 22d. ADDRESS <u>310 W. Montg. Ave. Rockville, Md.</u>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  |                               | 23b. DATE THEREOF <u>9/2/61</u> |   | 23c. NAME OF CEMETERY OR CREMATORY <u>Grandview Cemetery</u> |   |  | 23d. LOCATION (City, town or county) (State) <u>Johnstown, Pennsylvania</u> |  |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>  |  |                               |                                 |   |  | ADDRESS <u>Bethesda, Maryland</u>   |  | 25a. REC'D BY REGISTRAR <u>SEP 5 '61</u>                                    |  | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>   |  |

2222



Robert A. Humphrey Bethesda, Maryland  
Burial 2/24/61 Grandview Cemetery  
Johnston, Pennsylvania  
Sister W. Mary, Ave. McKeesport, Pa.



TO HOSPITAL OR AT RESIDING PHYSICIAN: The law requires that death certificates be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9399

## CERTIFICATE OF DEATH

09392

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>   |  |   |  |
| c. LENGTH OF STAY IN 1b <u>4 days 12 hrs.</u>  |  |  |  | d. STREET ADDRESS <u>12921 Columbia Pike</u>   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>   |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>Mr. Alfred R. Taylor</u>  |  | First <u>Richard</u> Middle <u>Taylor</u> Last <u>Taylor</u>   |  | 4. DATE OF DEATH <u>8-10-1961</u>  |  | Month <u>8</u> Day <u>10</u> Year <u>1961</u>                             |  |
| 5. SEX <u>Male</u>   |  | 6. COLOR OR RACE <u>White</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <u>8-30-1890</u>   |  |
| 9. AGE (In years last birthday) <u>70</u> yrs.   |  | IF UNDER 1 YEAR Months <u>8</u> Days <u>10</u> Hours <u>15</u> Min.                                    |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Patent Examiner</u>  |  | 11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u> |  |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Patent Office</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>America</u>  |  | 13. FATHER'S NAME <u>Hannis Taylor</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Leonora Le Baron</u>                          |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes give war or dates of service)  |  | 16. SOCIAL SECURITY NO. <u>None</u>  |  | 17. INFORMATION <u>Hospital Record</u>   |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><u>570.5</u> IMMEDIATE CAUSE (a) <u>Intestinal Obstruction</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>570.5</u> DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Gastric Ulcers, Congestive Failure with Fibrillation</u> |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                      |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>March 1961</u> to <u>Aug 10, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug 9, 1961</u> , and that death occurred at <u>1:48</u> M., from the causes and on the date stated above.  |  |  |  | 22a. SIGNATURE <u>Robert A. Hare</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE <u>Aug 10, 1961</u> |  |   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Robert A. Hare, MD.</u>  |  |  |  | 22d. ADDRESS <u>7600 Carroll Ave., T.P. Md.</u>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |  | 23b. DATE THEREOF <u>11 AUG. 1961</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMETERY</u>  |  | 23d. LOCATION (City, town or county) (State) <u>BLADENSBURG MD.</u>       |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Ronelli Funeral Home</u>   |  |  |  | ADDRESS <u>816 HST N.E. DC 2</u>   |  | 25a. REC'D BY REGISTRAR <u>AUG 11 '61</u> DATE                            |  |
|  |  |  |  | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>  |  |   |  |

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Handwritten text, mostly illegible due to fading and bleed-through. Some words like "The" and "and" are visible.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

9400  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

09393

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>                 |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bethesda</u>   |  |  |  | c. LENGTH OF STAY IN 1b<br><u>42 days 1 hr.</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Suburban Hospital</u>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Frank</u> Middle <u>Taylor</u> Last <u>Taylor</u>   |  |  |  | 4. DATE OF DEATH<br>Month <u>August</u> Day <u>20</u> Year <u>1961</u>   |  |  |  |
| 5. SEX<br><u>Male</u>   |  | 6. COLOR OR RACE<br><u>White</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>3/8/01</u>                                      |  |
| 9. AGE (In years last birthday)<br><u>60</u> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months <u>6</u> Days <u>1</u> Hours <u>1</u> Min. |  | 11. IF UNDER 24 HRS.<br>Hours <u>1</u> Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Builder</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Building</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Wash., D. C.</u>       |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>   |  |  |  |  |  |  |  |
| 13. FATHER'S NAME<br><u>Boyd Taylor</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Marion Lilley</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO.<br><u>578-18-1759</u>  |  | 17. INFORMANT<br><u>Gladys Taylor, wife</u>                            |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Metastasis</u><br><u>163X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Adeno Carcinoma of Right Lung Cavity</u> DUE TO<br>(c) _____ |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 weeks</u><br><u>3 months</u>  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) (County) (State)  |  |  |  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> 19 <u>20 Aug</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>20 Aug 1961</u> and that death occurred at <u>1958</u> M, from the causes and on the date stated above.   |  |  |  |  |  |  |  |
| 22a. SIGNATURE<br><u>William S. Murphy</u>  |  |  |  | 22b. DATE SIGNED<br><u>8/20/61</u>   |  | 22c. PHYSICIAN'S NAME (Type)<br><u>William S. Murphy</u>               |  |
| 22d. ADDRESS<br><u>615 W. Mont. Ave., Rockville, Md.</u>  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  |  |  | 23b. DATE THEREOF<br><u>8/22/61</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Potomac Church Cem.</u>       |  |
| 23d. LOCATION (City, town, or county) (State)<br><u>Potomac, Maryland</u>   |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Robert A. Pumphrey, Bethesda, Maryland</u>   |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <u>AUG 24 '61</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Arthur L. Frank</u>                   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificates be retained by the hospital or attending physician. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9401

09394

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b><br>c. LENGTH OF STAY IN 1b <b>31 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b> |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Minnesota</b> <b>b. COUNTY</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Saint Paul</b><br>d. STREET ADDRESS <b>1758 Agate Street</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <b>Robert Rhys Thomsen</b>   |  | <b>4. DATE OF DEATH</b><br>Month <b>August</b> Day <b>6</b> Year <b>19 61</b>  |  | <b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>August 6, 1934</b> <b>9. AGE</b> (In years last birthday) <b>27 yrs.</b> <b>IF UNDER 1 YEAR</b> Months Days Hours Min. |  |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Producer-Director</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Television</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Iowa</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>                                    |  | <b>13. FATHER'S NAME</b> <b>Edward J. Thomsen</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Toy</b>  |  |   |  |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b> <b>16. SOCIAL SECURITY NO.</b> <b>1956 - 1959 480-38-4494</b> <b>17. INFORMANT</b> <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Maryland</b>   |  | <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hepatic Failure</b><br>DUE TO (b) <b>Anaplastic carcinoma, primary unknown, with bone marrow, hepatic, retroperitoneal &amp; gastro-intestinal metastases</b><br>DUE TO (c) <b>metastases</b><br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)  |  |  |  | <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19 61</b><br>Hour a.m. p.m.   |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> <b>July 6, 1961 to August 6, 1961</b> <b>20g. (County)</b> <b>Polk County</b> <b>20h. (State)</b> <b>Iowa</b>  |  |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>August 6, 1961</b> <b>to</b> <b>August 6, 1961</b> <b>that (I) (we) last saw the deceased alive on</b> <b>August 6, 1961</b> <b>and that death occurred at</b> <b>8:15 PM</b> <b>from the causes and on the date stated above.</b>                                     |  |  |  |   |  |  |  |
| <b>22a. SIGNATURE</b> <b>Thorne S. Winter, III</b> <b>M.D.</b> <b>22b. DATE</b> <b>8/7/61</b>  |  | <b>22c. PHYSICIAN'S NAME</b> (Type) <b>THORNE S. WINTER, III, M.D.</b> <b>22d. ADDRESS</b> <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>  |  |   |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Bur-Transit</b> <b>23b. DATE THEREOF</b> <b>8/8/61</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Masonic Cemetery</b> <b>23d. LOCATION</b> (City, town or county) <b>Polk County, Des Moines</b> <b>(State)</b> <b>Iowa</b>   |  | <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert A. Pumphrey</b> <b>Bethesda, Maryland</b> <b>25a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>AUG 10 '61</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>  |  |   |  |  |  |

MEDICAL CERTIFICATION

I

050

M

(M)

(I)

Minnesota

State of

21 days

Booth

1775 Adams Street

The Clinical Center, Bethesda, Md.

Thomson

Five

Robert

27

August 6, 1931

White

Male

John

Television

Professor-Director

Harry Fox

Edward J. Thomson

The Federal Bureau

The Clinical Center, Bethesda, Md.

100-38-1001

1930 - 1932

Yes

1 week

Neurotic reaction

Anxiety, depression, irritability, insomnia, with some  
nausea, hiccups, retrosternal & gastro-intestinal 7 months  
relaxation

July 6, 1931

21 days

July 6,

August 6,

1931

X

The Clinical Center, National Institute  
of Health, Bethesda, Md.

Robert S. White, M.D., F.R.C.

John County, Des Moines

Massachusetts

San Francisco, Calif.

Robert A. Thompson, Bethesda, Maryland



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

| 1. PLACE OF DEATH   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  |  |  |  |
|---|--|--|--|--|--|--|--|
| a. COUNTY   |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) |  | a. STATE   |  | b. COUNTY  |  |
| Montgomery  |  | Takoma Park  |  | Maryland   |  | Prince George  |  |
| c. LENGTH OF STAY IN 1b   |  | 10 days  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |  | Adelphi 1657-  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  |  |  |  | d. STREET ADDRESS  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| Washington Sanitarium & Hospital  |  |  |  | 1929 Laguna Road   |  |  |  |
| 3. NAME OF DECEASED (Type or print)   |  |  |  | 4. DATE OF DEATH   |  | Month Day Year   |  |
| Raymond White Van Horn  |  |  |  | August 5   |  | 1961   |  |
| 5. SEX  |  | 6. COLOR OR RACE   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH   |  |
| Male  |  | white  |  |  |  | 9. AGE (in years last birthday) yrs. Months Days Hours Min.                                    |  |
|   |  |  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 11. BIRTHPLACE (County & State, or foreign country)  |  |
|   |  |  |  | Retired - Security - Guard   |  | Maryland U.S.A.  |  |
| 13. FATHER'S NAME   |  |  |  | 14. MOTHER'S MAIDEN NAME   |  |  |  |
| John A. Van Horn  |  |  |  | Annie E. Tucker  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |  |  |  | 16. SOCIAL SECURITY NO.  |  |  |  |
| No  |  |  |  | 577-05-4056  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  | 17. INFORMANT  |  |  |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  |  |  |  | Washington Sanitarium + Hospital Records   |  |  |  |
| 162.1 DUE TO  |  |  |  | BRONCHOPNEUMONIA with metastases to bone + pathological fractures of   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  | humerus.   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.   |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |  |  |
| 19  |  |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  |  |
|   |  |  |  | 20f. (City or town) (County) (State)   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from August 1960 to August 5, 1961 that (I) (we) last saw the deceased alive on August 5, 1961, and that death occurred at 11:20 PM, from the causes and on the date stated above. |  |  |  |  |  |  |  |
| 22a. SIGNATURE  |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  | 22b. DATE SIGNED   |  |
| BORIS RABKIN  |  |  |  | M.D.   |  | 8/6/61   |  |
| 22c. PHYSICIAN'S NAME (Type)  |  |  |  | 22d. ADDRESS   |  |  |  |
| BORIS RABKIN  |  |  |  | 1019 University Blvd, East Silver Spring   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE THEREOF  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City, town or county) (State)   |  |
| Aug. 9, 1961  |  | Fort Lincoln Cemetery  |  | Prince Georges   |  | Maryland   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE  |  |  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR  |  |
| Warner E. Pumphrey, Inc.  |  |  |  | 8434 Georgia Avenue  |  | 25b. REGISTRAR'S SIGNATURE   |  |
| Raymond A. Ziska  |  |  |  | Silver Spring, Md.   |  | DATE AUG 9 '61 Arthur S. Kline   |  |

1932

1932

(M)

Montgomery  
Tatam's Fork

10 days

Washington Sanatorium & Hospital  
1200 Khatam Street

West Hayville  
Maryland Prince George's

Male White X

Retired - Security Guard

John A. Van Horn

July 25, 1931 to

Maryland

N.A.A.

Annie E. Tucker

No

Washington Sanatorium & Hospital Record

Admission to Sanatorium  
for treatment of  
Tuberculosis

Prince George's

Post Office Cemetery

St. Louis, Mo.  
St. Louis, Mo.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

9403

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

09396

|  |                                  |   |                                     |   |   |  |                          |
|--|----------------------------------|---|-------------------------------------|---|---|--|--------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Montgomery</b> MARYLAND  |                                  |   |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> |   |  |                          |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Olney</b>   |                                  |   |                                     | c. LENGTH OF STAY IN 1b<br><b>3 days</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Woodbine</b> <b>13X-2</b> |                          |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Montgomery General Hospital</b>   |                                  |   |                                     | d. STREET ADDRESS<br><b>Carrs Mill Road</b>   |   |  |                          |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |                                     |   |   |  |                          |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Dwayne</b> Middle <b>Carl</b> Last <b>Viers</b>  |                                  |   |                                     | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>27</b> Year <b>1961</b>  |   |  |                          |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/30/60</b> |   | 9. AGE (In years lost birthday)<br>yrs. <b>10</b> | IF UNDER 1 YEAR<br>Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min.  | IF UNDER 24 HRS.<br>Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Infant</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>   |                                     | 11. BIRTHPLACE (State or foreign country)<br><b>VIRGINIA</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |                          |
| 13. FATHER'S NAME<br><b>Tivis C. Viers</b>   |                                  |   |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Agnes Rasnick</b>  |   |  |                          |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>—</b>   |                                     | 17. INFORMANT<br><b>Hospital Record</b>   |   | Address  |                          |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>571.0</b> DUE TO <b>Compulsive heart failure &amp; pul. edema</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) <b>Tuberculosis</b><br>(c) <b>Enteritis</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hours</b><br><b>8 days</b> |                                  |   |                                     |   |   |  |                          |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Ascariasis, anemia</b>   |                                  |   |                                     |   |   |  |                          |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                     |   |   |  |                          |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                     | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |                          |
| 21. I certify that (I) (this hospital) attended the deceased from <b>8/27</b> to <b>8/27</b> 19 <b>61</b> , that (I) <del>last</del> saw the deceased alive on <b>8/27</b> 19 <b>61</b> , and that death occurred at <b>4:40 A.M.</b> from the causes and on the date stated above.  |                                  |   |                                     |   |   |  |                          |
| 22a. SIGNATURE<br><b>G. F. Meadors, M.D.</b>   |                                  |   |                                     | 22b. DATE SIGNED<br><b>8/27/61</b>  |   | 22c. PHYSICIAN'S NAME (Type)<br><b>G. F. Meadors, M.D.</b>   |                          |
| 22d. ADDRESS<br><b>Damascus, Maryland</b>  |                                  |   |                                     |   |   |  |                          |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |                                  | 23b. DATE THEREOF<br><b>Aug. 27 1961</b>  |                                     | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Prather</b>  |   | 23d. LOCATION (City, town, or county) (State)<br><b>Prather Virginia</b>   |                          |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Francis H. Barber</b>   |                                  |   |                                     | ADDRESS<br><b>Laytonsville, Md.</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>SEP 1 '61</b>   |                          |
|  |                                  |   |                                     | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hines</b>  |   |  |                          |

MEDICAL CERTIFICATION

3903



Montgomery

Shirley

3 days

Woodbine

Montgomery General Hospital

Carter Hill Road

Dwayne

Carl

Where

August 27

Male White

10/30/60

White

David C. Vickers

James H. Vickers

Montgomery Record

E. F. Sanders, M.D.

Removal Aug. 27 1961

Lexington, Va.

Item 18 File 293 8-29-61  
**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

9404

09397

|   |                            |  |                                      |   |   |  |  |
|---|----------------------------|--|--------------------------------------|---|---|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Montgomery</u> MARYLAND   |                            |  |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |                            |  |                                      | c. LENGTH OF STAY IN 1b <u>D.O.A.</u>   |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>   |                            |  |                                      | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>MARK ANTONIO WADE</u>  |                            |  |                                      | 4. DATE OF DEATH Month Day Year <u>August 6 1961</u>  |   |  |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>C.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAY 27, 1961</u> |   | 9. AGE (In years lost birthday) yrs. <u>2</u> | IF UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u> | IF UNDER 24 HRS. <u>10</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>  |                            | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>   |                                      | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                                     |  |
| 13. FATHER'S NAME <u>Cornelius Wallace Wade</u>   |                            |  |                                      | 14. MOTHER'S MAIDEN NAME <u>Izetta Bruce</u>  |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>   |                            | 16. SOCIAL SECURITY NO. <u>-</u>   |                                      | 17. INFORMANT <u>C. Wallace Wade (father)</u>   |   | Address <u>Same as above</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory failure</u><br><u>492X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute bronchitis</u> DUE TO<br>(c) <u>pneumonia</u><br><u>Possible virus infection</u> |                            |  |                                      |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 wks.</u><br><u>?</u>                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(supplemental pathological report may be sent later)</u>   |                            |  |                                      |   |   |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                            | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |                                      |   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>   |                            | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 25 1961</u> to <u>Aug. 3 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug. 3 1961</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.   |                            |  |                                      |   |   |  |  |
| 22a. SIGNATURE <u>Katharine A. Chapman</u>  |                            |  |                                      | 22b. ADDRESS <u>3924 Bala St.</u>   |   | 22c. PHYSICIAN'S NAME (Type)   |  |
| 22d. SIGNATURE <u>Robert L. Snowden</u>   |                            |  |                                      | 22e. REC'D BY REGISTRAR <u>Aug 11 '61</u>   |   | 22f. REGISTRAR'S SIGNATURE <u>Robert L. Snowden</u>                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                            | 23b. DATE THEREOF <u>8/9/61</u>  |                                      | 23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>  |   | 23d. LOCATION (City, town, or county) (State) <u>Rockville, MD</u>             |  |

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

- 2074192xv4

(M)

3404

STATE OF DEATH

DEPARTMENT OF HEALTH

1920

1920

1920

1920



TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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9405

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09398

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>               |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b>   |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>56 Bethesda</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>5202 Worthington Drive</b>   |  |  |  | d. STREET ADDRESS<br><b>5202 Worthington Drive</b>  |  |   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Arthur</b> Middle <b>J</b> Last <b>Wadsworth</b>  |  |  |  | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>21</b> Year <b>1961</b>  |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>4/8/67</b>   |  |
| 9. AGE (In years last birthday)<br><b>94</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b>                                 |  | IF UNDER 24 HRS.<br>Hours <b>0</b> Min. <b>0</b>  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Editor</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Gov't Printing</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>New York</b>              |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  |   |  |   |  |
| 13. FATHER'S NAME<br><b>Alvin Wadsworth</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>(Unknown) Sherman</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)<br><b>None</b> |  | 17. INFORMANT<br>Address<br><b>Robert L. Wadsworth-son-same 2d</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS &amp; MYOCARDIAL INFARCTION</b><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROSIS, GENERALIZED</b><br>DUE TO<br>(c) <b>16 DAYS</b><br><b>15 YEARS</b> |  |  |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)    |  |
| 20f. (City or town) (County) (State)  |  |  |  |   |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>AUG. 3</b> 19 <b>61</b> , to <b>AUG. 21</b> 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>AUG. 17</b> 19 <b>61</b> , and that death occurred at <b>8 AM</b> , from the causes and on the date stated above.   |  |  |  |   |  |   |  |
| 22a. SIGNATURE<br><b>Philip R. James</b>  |  |  |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        |  | 22b. DATE SIGNED<br><b>8/21/61</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Philip R. James</b>  |  |  |  | 22d. ADDRESS<br><b>Washington Clinic, Washington D. C.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>8/23/61</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glenwood Cemetery</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>Washington, D. C.</b> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Pumphrey</b>   |  |  |  | ADDRESS<br><b>Bethesda, Maryland</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 24 '61</b>                         |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |  |   |  |

203

1913-1914

1914-1915

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1928-1929

1929-1930

1930-1931

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9406

## CERTIFICATE OF DEATH

09399

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, (Rural)</b> <b>25 days</b><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Md.</b>  |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b><br>d. STREET ADDRESS <b>5802 Winner Ave</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <b>Sharon Diane WALKER</b><br>First Middle Last<br><b>5. SEX</b> <b>Female</b> <b>6. COLOR OR RACE</b> <b>Cauc</b><br><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>11 November 53</b><br><b>9. AGE</b> (In years last birthday) <b>7 yrs.</b> <b>10. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b><br><b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Annapolis, Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b> |  |  |  | <b>13. FATHER'S NAME</b> <b>James Walter WALKER</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Bettye Jean MARTIN</b><br><b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b> <b>16. SOCIAL SECURITY NO.</b> <b>---</b> <b>17. INFORMANT</b> <b>(M) Mrs Bettye J. GAVIN same as #2</b><br><b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Staphylococcal Pneumonia</b><br>DUE TO <b>587.3</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fibrocystic Disease</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  | <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/><br><b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br><b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> <b>(County)</b> <b>(State)</b>   |  |  |  |
| <b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8-1-</b> <b>1961</b> to <b>8-26</b> <b>1961</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>8-26-</b> <b>1961</b> and that death occurred at <b>2:30AM</b> from the causes and on the date stated above.  |  |  |  | <b>22a. SIGNATURE</b> <b>M.C. O'Bannon</b> M.D. <b>22b. DATE SIGNED</b> <b>8-26-61</b><br><b>22c. PHYSICIAN'S NAME (Type)</b> <b>M. C. O'BANNON, LT MC USN</b> <b>22d. ADDRESS</b> <b>U.S. Naval Hospital, Bethesda, Md.</b>   |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b> <b>23b. DATE THEREOF</b> <b>29 August 1961</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Druid Ridge</b> <b>23d. LOCATION</b> (City, town or county) <b>Pikesville, Maryland</b> <b>(State)</b>   |  |  |  | <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Frank H. NEWELL</b> <b>24b. ADDRESS</b> <b>Funeral Home Pikesville, Md.</b> <b>24c. REC'D BY REGISTRAR</b> <b>DATE AUG 30 '61</b> <b>24d. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Kraus</b>  |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Montgomery

Maryland

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Seaside, (Nurs.)

25 days

Baltimore

U.S. Naval Hospital, Bethesda, Md.

5805 Winner Ave.

Sharon

Diane

WALTER

August 20

GA

Female

Child

11 November 53

None

None

Annapolis, Maryland

USA

James Walter WALKER

Betty Jean MARTIN

Mo - - - - - (M) Mrs. Betty J. DAVIN same as 82

U.S. Naval Hospital, Bethesda, Md.

Pikesville, Maryland

Frank H. NEWELL Funeral Home Pikesville, Md.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9407

## CERTIFICATE OF DEATH

09400

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>  |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>         |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Olney</u>   |  | c. LENGTH OF STAY IN 1b<br><u>10 days</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Fulton</u>  |  | d. STREET ADDRESS<br><u>13x-2</u>                                |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Montgomery General Hospital</u>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br>First <u>George</u> Middle <u>Henry</u> Last <u>Walter</u>  |  |   |  | <b>4. DATE OF DEATH</b><br>Month <u>August</u> Day <u>29</u> Year <u>1961</u>  |  |  |  |
| 5. SEX <u>Male</u>   |  | 6. COLOR OR RACE <u>White</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | B. DATE OF BIRTH <u>Dec. 27, 1879</u>                            |  |
| 9. AGE (In years less birthday) <u>80</u> yrs.   |  | IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>0</u>  |  | IF UNDER 24 HRS.<br>Hours <u>0</u> Min. <u>0</u>   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Farmer</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Farm</u>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Maryland</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>                      |  |
| 13. FATHER'S NAME<br><u>George Walter</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Caroline (unknown)</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  | 16. SOCIAL SECURITY NO. (If yes give number or date of service)   |  | 17. INFORMANT<br><u>Hospital Records</u>   |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]   |  |   |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute pyelonephritis</u>  |  |   |  |  |  |  |  |
| DUE TO (b) <u>Nodular hyperplasia of prostate</u>  |  |   |  |  |  |  |  |
| DUE TO (c) <u>Arteriosclerotic heart disease</u>   |  |   |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)  |  |   |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <u>19</u> p.m.  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                             |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 19, 1961</u> to <u>Aug. 29, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug. 28, 1961</u> , and that death occurred at <u>6:58 PM</u> , from the causes and on the date stated above. |  |   |  |  |  |  |  |
| 22a. SIGNATURE<br><u>Charles S. Whitaker</u> M.D.  |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  | 22b. DATE SIGNED<br><u>Aug. 29, 1961</u>                         |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Charles S. Whitaker, M. D.</u>  |  |   |  | 22d. ADDRESS<br><u>Clarksville, Maryland</u>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 23b. DATE THEREOF<br><u>8/31/61</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>St Pauls Lutheran</u>   |  | 23d. LOCATION (City, town or county) (State)<br><u>Fulton Md</u> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>DeWitt Canalean, Daniel, Md</u>   |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>SEP 6 '61</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Arthur L. Frame</u>             |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

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Director Page

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9408

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09401

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b><br>c. LENGTH OF STAY IN 1b <b>DOA</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Montg.</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b><br>d. STREET ADDRESS <b>701 Ritchie Ave.</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Roy</b> Middle <b>Engine</b> Last <b>Walter</b>   |  | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>30</b> Year <b>1961</b>   |   |
| 5. SEX <b>M</b>   | 6. COLOR OR RACE <b>W</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>7.14.31</b>   |
| 9. AGE (in years last birthday) <b>30</b> yrs.  |  | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b>   | IF UNDER 24 HRS.<br>Hours <b>0</b> Min. <b>0</b>                              |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance man</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Wash. S S C</b>   |   |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   |
| 13. FATHER'S NAME <b>Whitney Walker</b>   |  | 14. MOTHER'S MAIDEN NAME <b>Beatrice C. Weaver</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes Army</b>   |  | 16. SOCIAL SECURITY NO. <b>215-24-0148</b>   |   |
| 17. INFORMANT <b>Whitney Walter</b>   |  | Address <b>701 Ritchie Ave, Sil. Spring, Md.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |   |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>8945</b> DUE TO <b>SUFFOCATION</b><br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>DROWNING</b><br>(c) <b>SYNCOPE FROM METHANE INHALATION</b>   |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Overcome by gas in manhole and fell in water</b>  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><b>10:15 a.m. 7/30 19 61</b>   | 20d. INJURY OCCURRED<br>While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>street</b>   | 20f. (City or town) <b>Bethesda</b> (County) <b>Montg.</b> (State) <b>Md.</b> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> |  |  |   |
| ACTUAL SIGNATURE <b>Frank J. Broschart</b>  |  | DATE SIGNED <b>8/30/61</b>   |   |
| EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 22b. DATE THEREOF <b>Sept 2, 1961</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY <b>George Washington Cemetery</b>  |  | 22d. LOCATION (City, town, or country) <b>Prince Georges County Md.</b>  |   |
| 23. FUNERAL DIRECTOR <b>Arthur Walters, 254 Carroll St NW. DC</b>   |  | 24. REC'D BY REGISTRAR <b>SEP 5 '61</b>  |   |
| 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Henth</b>   |  |  |   |

MEDICAL CERTIFICATION

CAL EXAMINER: This certificate should be executed within 72 hours after death. If any other person executes the certificate, writing the word "pending" in pencil in item 18. Pages 1, 2, and 3 to the funeral home. Pages 4 and 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed in 84 days after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9409 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09402

|  |   |   |   |   |  |  |  |
|--|---|---|---|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b><br>c. LENGTH OF STAY IN 1b <b>Do A.</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanitarium + Hosp.</b>   |   |   |   | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Montgomery</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b><br>d. STREET ADDRESS <b>2208 Parker Ave</b> |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Elmer Mervin Ward</b>  |   | 4. DATE OF DEATH<br>Month <b>8</b> Day <b>27</b> Year <b>1961</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 5. SEX <b>M</b>  | 6. COLOR OR RACE <b>W</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11-29-01</b>   | 9. AGE (In years last birthday) <b>59</b> yrs.  | IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HRS.<br>Hours Min. |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Civil Engineer, Nat'l. Academy of Science</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country) <b>Iowa</b>   |  |  |  |
| 13. FATHER'S NAME<br><b>Reuben C. Ward</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Lena Markesow</b>  |   |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>NO</b>   |   | 16. SOCIAL SECURITY NO.<br><b>229-25-7922</b>   |   | 17. INFORMANT<br><b>Mrs Winona Ward wife</b><br>Address   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE CONGESTIVE HEART FAILURE</b><br>DUE TO (b) <b>MYOCARDIAL FIBROSIS AND INSUFFICIENCY</b><br>DUE TO (c) <b>OLD LEFT ANTERIOR DESCENDING CORONARY OCCLUSION</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br>INTERVAL BETWEEN ONSET AND DEATH <b>HOURS</b> |   |   |   |   |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)   | (County)  | (State)  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |   |   |   |   |  |  |  |
| ACTUAL SIGNATURE <b>Frank J. Brosch</b>  |   | M.D.  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |  |  |
| EXAMINER'S NAME (Type) <b>FRANK J. BROSCHE</b>   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   | DATE SIGNED <b>8-28-61</b>  |  |  |  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   | Address (Street, city, town, or county)   |   |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>Aug. 30, 1961</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Lincoln Cemetery</b>  | 22d. LOCATION (City, town, or country) (State)<br><b>Prince George's County Md.</b> |   |  |  |  |
| 23. FUNERAL DIRECTOR<br><b>WARNER E. PUMPHREY, INC. SILVER SPRING, MD.</b><br><b>Raymond C. Ziska</b>  |   | 24a. REC'D BY REGISTRAR<br><b>AUG 30 '61</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |  |  |  |

1921

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1921

(M)

(I)



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>47X-3</u>                          |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Takoma Park D.C.A.</u>  |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Washington DC</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Wash SAN + Hosp</u>   |   | d. STREET ADDRESS<br><u>2318 16th St SE</u>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Clarence</u> Middle <u>Leslie</u> Last <u>Ware</u>  |   | 4. DATE OF DEATH<br>Month <u>8</u> Day <u>19</u> Year <u>1961</u>   |   |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W</u>                         | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>11-16-02</u>   |
| 9. AGE (In years last birthday)<br><u>58</u> yrs.  |   | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>  | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Mover</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Furniture Bus</u>   | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |
| 12. CITIZEN OF WHAT COUNTRY<br><u>U.S.A</u>  |   | 13. FATHER'S NAME<br><u>Wm F Ware</u>   |   |
| 14. MOTHER'S MAIDEN NAME<br><u>Maudie Johnson</u>  |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give year or dates of service)<br><u>No</u>                                    |   |
| 16. SOCIAL SECURITY NO.<br><u>  </u>   |   | 17. INFORMANT<br><u>Ruth V Ware</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <u>  </u><br>(c) <u>  </u> DUE TO<br>(e), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of hypertension</u> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u>   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>  </u> |
| 20c. TIME OF INJURY<br>Hour <u>  </u> e.m. <u>  </u> p.m. <u>  </u>  | Month, Day, Year<br><u>  </u> <u>  </u> <u>19</u> | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>  </u>                       |
| 20f. (City or town)<br><u>  </u>   |   | (County)<br><u>  </u> (State)<br><u>  </u>  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |   |   |   |
| ACTUAL EXAMINER'S NAME (Type)<br><u>Frank J Broschert</u>  |   | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                     |   |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify)<br><u>Burial</u>  |   | 22b. DATE THEREOF<br><u>Aug 22, 1961</u>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Cedar Hill</u>  |   | 22d. LOCATION (City, town, or country)<br><u>Suitland md</u>  |   |
| 23. FUNERAL DIRECTOR<br><u>Lee Funeral Home - Wash DC</u>  |   | 24a. REC'D BY REGISTRAR<br><u>AUG 22 '61</u>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Hines</u>   |   | DATE SIGNED<br><u>8-19-61</u>   |   |

(M)





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9411

## CERTIFICATE OF DEATH

09404

|   |                                  |  |  |   |   |   |  |
|---|----------------------------------|--|--|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Olney</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>1 day</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>03 Clarksburg</b>                                      |   | d. STREET ADDRESS<br><b>1 Kingsby Road</b>                              |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Montgomery General Hospital</b>  |                                  |  |  |   |   |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Richard</b> Middle <b>Albert</b> Last <b>Watkins</b>   |                                  |  |  | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>31</b> Year <b>19 61</b>   |   |   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Aug. 12, 1866</b> | 9. AGE (In years last birthday)<br><b>95 yrs.</b>   | IF UNDER 1 YEAR<br>Months <b>95</b> Days <b>00</b> Hours <b>00</b> Min. <b>00</b> | IF UNDER 24 HRS.<br>Hours <b>00</b> Min. <b>00</b>                      |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Brick layer</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Pennsylvania</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>                             |  |
| 13. FATHER'S NAME<br><b>Clyde A. Watkins</b>  |                                  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mandy Watkins</b>  |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>none</b>   |  | 17. INFORMANT<br><b>Hospital Records</b>  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO (b) <b>Bronchopneumonia, bilateral</b><br>DUE TO (c) <b>Asphyxia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Asphyxia</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>7 days</b> |                                  |  |  |   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |  |  |   |   |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                  |  |  |   |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)                                    |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 10, 1960</b> to <b>August 31, 1961</b> , that (I) (we) last saw the deceased alive on <b>August 31, 1961</b> , and that death occurred at <b>9:35 AM</b> , from the causes and on the date stated above.  |                                  |  |  |   |   |   |  |
| 22a. SIGNATURE<br><b>James P. Kerr</b>  |                                  |  |  | 22b. DATE SIGNED<br><b>8/31/61</b>  |   |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>James P. Kerr, M. D.</b>   |                                  |  |  | 22d. ADDRESS<br><b>Damascus, Maryland</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>9-3-61</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. View</b>   |   | 23d. LOCATION (City, town or county) (State)<br><b>Purdum, Maryland</b> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Francis W. Barber</b>  |                                  |  |  | 25a. REC'D BY REGISTRAR<br><b>Laytonsville, Md.</b>   |   |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>SEP 5 '61</b>  |                                  |  |  | 25c. DATE<br><b>Arthur S. Knap</b>  |   |   |  |

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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RECEIVED  
SEP 2 1940  
U.S. DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D.C.

# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### 9412 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09405

|   |  |   |  |   |  |                               |  |  |  |                                     |  |  |  |  |  |  |  |  |  |
|---|--|---|--|---|--|-------------------------------|--|--|--|-------------------------------------|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u><br>c. LENGTH OF STAY IN 1b <u>DOA</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hosp</u>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>District of Columbia</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u><br>c. STREET ADDRESS <u>1217 G ST. S.E.</u><br>d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                               |  |  |  |                                     |  |  |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Luther Ray Weakley</u>  |  | 4. DATE OF DEATH<br>Month <u>8</u> Day <u>23</u> Year <u>1961</u> |  | 5. SEX <u>Male</u>  |  | 6. COLOR OR RACE <u>White</u> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>11-23-00</u> |  | 9. AGE (In years last birthday) <u>60</u> yrs.                           |  | 10. IF UNDER 1 YEAR<br>Months <u>2</u> Days <u>3</u> |  | 11. IF UNDER 24 HRS.<br>Hours <u>19</u> Min. <u>61</u>                         |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salvation Army</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Truck Driver - Worker</u>  |  |                               |  | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u>  |  |                                     |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                               |  |  |  |  |  |  |  |
| 13. FATHER'S NAME <u>James Weakley</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Ada ?</u>   |  |                               |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  |                                     |  | 16. SOCIAL SECURITY NO. <u>578-05-8567</u>                               |  |  |  | 17. INFORMANT <u>Edna M. Weakley</u> Address <u>1217 G St. S.E. Wash. D.C.</u> |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>420.1</u><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Interval between onset and death sudden</u> |  |   |  |   |  |                               |  |  |  |                                     |  |  |  |  |  |  |  |  |  |
| 12a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |   |  | 12b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |                               |  |  |  |                                     |  |  |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <u>19</u> p.m.   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |                               |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |                                     |  | 20f. (City or town) (County) (State)                                     |  |  |  |  |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |  |   |  |   |  |                               |  |  |  |                                     |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Frank J. Broschant</u>  |  |   |  | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |                               |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |                                     |  | DATE SIGNED <u>8-23-61</u>   |  |  |  |  |  |  |  |
| EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>  |  |   |  | Address (Street, city, town, or county)   |  |                               |  |  |  |                                     |  |  |  |  |  |  |  |  |  |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>  |  |   |  | 22b. DATE THEREOF <u>Aug 26, 1961</u>   |  |                               |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>  |  |                                     |  | 22d. LOCATION (City, town, or country) (State) <u>Suitland, Maryland</u> |  |  |  |  |  |  |  |
| 23. FUNERAL DIRECTOR <u>W. W. CHAMBERS CO</u>   |  |   |  | ADDRESS <u>517 11th St SE Wash. D.C.</u>  |  |                               |  | 24a. REC'D BY REGISTRAR <u>AUG 25 '61</u>  |  |                                     |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>                         |  |  |  |  |  |  |  |

MEDICAL CERTIFICATION

(M)

099

(I)

2

1918

1918

(M)

Trust Door -

James Wesley

None

Edna M. Wesley

W. W. CHAMBERS CO  
Burlington, N.C.  
27111  
Burlington, N.C.  
27111

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Filed 9/11/61 mh

9413

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>  |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>   |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>  |  |   |  | d. STREET ADDRESS <u>3508 Farthing Drive</u>  |  |   |   |
| 3. NAME OF DECEASED (Type or print) First <u>Infant Boy</u> Middle <u>WERMTER</u> Last <u>WERMTER</u>   |  |   |  | 4. DATE OF DEATH Month <u>Aug</u> Day <u>30</u> Year <u>1961</u>  |  |   |   |
| 5. SEX <u>MALE</u>  |  | 6. COLOR OR RACE <u>WHITE</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <u>Aug. 30, 1961</u>                   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country) <u>Md.</u>  |  | 12. CITIZEN OF WHAT COUNTRY?                            |   |
| 13. FATHER'S NAME <u>RAYMOND WERMTER</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Adelaide BLAKE</u>  |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>770.5</u> DUE TO <u>Anoxia</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atelectasis</u><br>(c) <u>Prematurely Engorged Heart with Focalis</u> |  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                    |   |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED  |  |   |  |   |  |   |   |
| ACTUAL SIGNATURE <u>Michael J. Buckley</u> M.D.   |  |   |  | PHYSICIAN'S NAME (Type)   |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  | 22b. DATE THEREOF <u>9-1-61</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON CEMETERY ARLINGTON</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>VA</u> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter H. Hauler</u> ADDRESS <u>3851 - G St. Ave</u>  |  |   |  | 24a. REC'D BY REGISTRAR   |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>       |   |

2074314XV 4

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed by the Medical Examiner, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                               |   |  |  |   |  |  |  |  |  |  |  |  |
|--|--|-------------------------------|---|--|--|---|--|--|--|--|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                               |   |  |  |   |  |  |  |  |  |  |  |  |
| 9414 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09406   |  |                               |   |  |  |   |  |  |  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Montgomery</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u><br>c. LENGTH OF STAY in 1b <u>D.O.A.</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>   |  |                               |   |  | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Montgomery</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>16 Silver Spring</u><br>d. STREET ADDRESS <u>447 Southampton Drive</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Albert Claude Whitlock</u>  |  |                               |   |  | 4. DATE OF DEATH <u>August 27</u> 19 <u>61</u><br>Month Day Year   |   |  |  |  |  |  |  |  |  |
| 5. SEX <u>male</u>   |  | 6. COLOR OR RACE <u>white</u> |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>Oct. 15, 1891</u> 69 yrs.                             |  | 9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min. |  |  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>   |  |                               |   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |   |  |  |  | 11. BIRTHPLACE (State or foreign country) <u>Roanoke, Virginia</u>                             |  |  |  |  |
| 13. FATHER'S NAME <u>Samuel Whitlock</u>   |  |                               |   |  | 14. MOTHER'S MAIDEN NAME <u>Fisher</u>   |   |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>   |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)   |  |                               |   |  | 16. SOCIAL SECURITY NO. <u>unknown</u>   |   |  |  |  | 17. INFORMANT <u>wife</u> Address <u>447 Southampton Drive</u>                                 |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u><br>Conditions, if any, which gave rise to immediate cause (b) <u>420.1</u><br>(a), stating the underlying cause last. DUE TO (c) <u>420.1</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous coronary disease</u> |  |                               |   |  |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>   |  |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</u>   |  |                               |   |  |  |   |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |
| 22d. TIME OF INJURY<br>Hour <u>o.m.</u> <u>19</u> p.m.   |  |                               | 22d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)    |  |  | 20f. (City or town) (County) (State)           |  |  |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |                               |   |  |  |   |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  |  |  |
| ACTUAL SIGNATURE <u>Frank J. Bluschart</u> M.D.  |  |                               |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |  |  |  | DATE SIGNED <u>8-27-61</u>   |  |  |  |  |
| EXAMINER'S NAME (Type) <u>FRANK J. BLUSCHART</u>   |  |                               |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |  |  |  | Address (Street, city, town, or county)  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |  |                               | 22b. DATE THEREOF <u>8-30-61</u>  |  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON NATIONAL SWITLAND MD</u> |  |  | 22d. LOCATION (City, town, or country) (State) |  |  |  |  |  |
| 23. FUNERAL DIRECTOR <u>W W CHAMBERS &amp; CO RIVERDALE MD</u> ADDRESS   |  |                               |   |  | 24a. REC'D BY REGISTRAR <u>AUG 29 '61</u> DATE   |   |  |  |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. King</u>   |  |  |  |  |

THE STATE  
OF NEW YORK

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## CERTIFICATE OF DEATH

Reg. Dist. No. 09407

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Montgomery</i> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>  |                                  | c. LENGTH OF STAY IN 1b <i>15 yrs</i>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><i>11,710 Georgia Avenue</i>   |                                  | d. STREET ADDRESS<br><i>11710 Georgia Ave</i>   |  |
| 3. NAME OF DECEASED<br>(Type or print) <i>Martha Crossan Willard</i>   |                                  | 4. DATE OF DEATH<br>Month <i>Aug</i> Day <i>23</i> Year <i>1961</i>   |  |
| 5. SEX<br><i>Female</i>  | 6. COLOR OR RACE<br><i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>Feb 21 1884</i> |
| 9. AGE (In years last birthday) <i>77</i> yrs.   |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Homemaker</i>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Own Home</i>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><i>Scotland</i>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  |
| 13. FATHER'S NAME<br><i>James Cumming Halliday</i>   |                                  | 14. MOTHER'S MAIDEN NAME<br><i>M.S. Walker</i>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <i>No</i>  |                                  | 16. SOCIAL SECURITY NO.<br><i>None</i>  |  |
| 17. INFORMANT<br><i>Mrs Margaret M. Hahn</i>   |                                  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i><br>443x DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Heart Disease</i><br>(c) <i>Arteriosclerosis - Senility</i><br>INTERVAL BETWEEN ONSET AND DEATH<br><i>Sudden</i><br><i>Years</i>                          |                                  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <i>May 29 1960</i> to <i>Aug 23 1961</i> , that I last saw the deceased alive on <i>Aug 23 1961</i> , and that death occurred at <i>12:45 PM</i> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><i>Philip E. Jones M.D. 918 Ellsworth Drive</i><br>ACTUAL SIGNATURE<br><i>Philip E. Jones</i><br>PHYSICIAN'S NAME (Type) <i>Silver Spring Md.</i> |                                  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                                  | 22b. DATE THEREOF<br><i>8/28/61</i>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><i>Cedar Hill Cemetery</i>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><i>Prince Georges County, Maryland</i>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><i>Raymond A. Ziska</i><br>ADDRESS<br><i>8434 Georgia Avenue</i><br><i>Warner E. Pumphrey, Inc. Silver Spring, Maryland</i>  |                                  | 24a. REC'D BY REGISTRAR<br>DATE <i>AUG 25 61</i>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><i>Arthur S. Hahn</i>  |                                  |   |  |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital and attending physician.

TO FUNERAL HOME: After this certificate has been signed by the attending physician, it should be completely filled in and completely filled in. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

BP



TO HOSPITAL OR ATENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9415

## CERTIFICATE OF DEATH

09408

|   |  |   |   |  |  |   |
|---|--|---|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |  |   | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> |  |  |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Wheaton</b>  |  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X Wheaton</b>  |  |  |   |
| c. LENGTH OF STAY IN 1b<br><b>Since 1952</b>  |  |   | d. STREET ADDRESS<br><b>11812 Valleywood Drive</b>  |  |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>11,812 Valleywood Drive</b><br><b>not in hospital</b>  |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Howard Henry Wilson</b>  |  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>Aug. 9 1961</b>  |  |  |   |
| 5. SEX<br><b>M</b>  |  |   | 6. COLOR OR RACE<br><b>W</b>  |  |  |   |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |   | 8. DATE OF BIRTH<br><b>Feb. 14, 1884</b>  |  |  |   |
| 9. AGE (In years last birthday)<br><b>77</b> yrs.   |  |   | IF UNDER 1 YEAR<br>Months Days<br><b>77</b>   |  |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Printer</b>   |  |  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Philadelphia, Pa.</b>   |  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |   |
| 13. FATHER'S NAME<br><b>William Henry Wilson</b>  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Helen Marbel</b>   |  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  |  |   | 16. SOCIAL SECURITY NO.<br><b>NONE</b>  |  |  |   |
| 17. INFORMANT<br><b>William H. Wilson</b>   |  |   | Address<br><b>11510 Mapleview Dr. S.S. Md.</b>  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b><br>DUE TO<br>331X<br>Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerosis, General</b><br>(c) <b>DUE TO</b><br>(e), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 weeks</b><br><b>6 years</b>                              |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |   |
| 20f. (City or town)<br><b>May 1955 to Aug. 8, 1961</b>  |  | 20g. (County)<br><b>Montgomery</b>  |   | 20h. (State)<br><b>Md.</b>   |  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>May 1955</b> to <b>Aug. 8, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug. 8, 1961</b> , and that death occurred at <b>5:15 PM</b> , from the causes and on the date stated above.   |  |   |   |  |  |   |
| 22a. SIGNATURE<br><b>John C. Yu</b>   |  |   | 22b. DATE SIGNED<br><b>Aug. 9, 1961</b>   |  |  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>John C. Yu</b>   |  |   | 22d. ADDRESS<br><b>4912 Adrian St., Rockville, Md.</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>8/12/61</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Cemetery</b>         |  |   |
| 23d. LOCATION (City, town or county)<br><b>Montgomery</b>   |  | 23e. (State)<br><b>Maryland</b>   |   | 23f. ADDRESS<br><b>Silver Spring, Maryland</b>                         |  |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Warner E. Pumphrey, Inc.</b>   |  | 24a. ADDRESS<br><b>8434 Georgia Avenue</b>  |   | 25a. REC'D BY REGISTRAR<br><b>AUG 14 '61</b>                           |  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hines</b>  |  |   |   |  |  |   |

VR A15 (4)  
15M 9/60



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12202

M

Robert James

Marjorie

Marjorie

Robert

Robert

Since 1952

Robert James

11812 Volkswagon Drive

Howard Henry

Wilson

Feb 14 1954 27

Robert

Philadelphia, Pa

William Henry Wilson

Melrose

none

William H. Wilson

Cerebral Vascular Accident  
Anterior, Central

2 weeks  
6 years

Aug 8 61

May 22 Aug 8 61

John C. Lee

X

412 Adams St, Kansas City

Robert James  
11812 Volkswagon Drive  
Philadelphia, Pa

Marjorie  
11812 Volkswagon Drive  
Philadelphia, Pa



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9417

## CERTIFICATE OF DEATH

09409

|  |  |  |  |  |  |   |  |  |  |   |  |   |  |   |  |                                |  |
|--|--|--|--|--|--|---|--|--|--|---|--|---|--|---|--|--------------------------------|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Montgomery</b> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Wheaton</b><br>c. LENGTH OF STAY IN 1b<br><b>2 months</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Wheaton Nursing Home</b><br><b>11901 Georgia Ave. S.S.</b>   |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Mont.</b></span><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b><br>d. STREET ADDRESS<br><b>5021 Bradley Blvd.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |  |   |  |   |  |   |  |                                |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br><b>Nell N. Wilson</b>   |  | <b>4. DATE OF DEATH</b><br>Month <b>8</b> Day <b>10</b> Year <b>1961</b> |  | <b>5. SEX</b><br><b>Female</b>   |  | <b>6. COLOR OR RACE</b><br><b>White</b>   |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | <b>8. DATE OF BIRTH</b><br><b>Sept 16, 1886</b>     |  | <b>9. AGE</b> (In years, birthday)<br><b>74</b> yrs.                              |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |  | IF UNDER 24 HRS.<br>Hours Min. |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>   |  |   |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><b>Chattanooga, Tenn.</b>  |  |   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.</b>                                |  |   |  |                                |  |
| <b>13. FATHER'S NAME</b><br><b>Charles T. Neal</b>   |  |  |  |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Emma Bepue</b>  |  |  |  |   |  |   |  |   |  |                                |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  |  |  | <b>16. SOCIAL SECURITY NO.</b><br><b>None</b>  |  |   |  | <b>17. INFORMANT</b><br><b>Thomas Wilson-son-</b>  |  |   |  | Address <b>5315 Edgemoor La Bethesda, Maryland</b>                                |  |   |  |                                |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral vascular accidents +</b><br><b>331X</b> DUE TO <b>Coronary heart disease due to</b><br>Conditions, if any, which gave rise to immediate cause (b) <b>Generalized arteriosclerosis</b><br>(a), stating the underlying cause last. (c) <b>Generalized arteriosclerosis</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |  |  |  |  |  |   |  |  |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>weeks</b><br><b>months</b><br><b>years</b> |  |                                |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |  |  |   |  |  |  |   |  |   |  |   |  |                                |  |
| <b>20c. TIME OF INJURY</b><br>Hour a.m. p.m. <b>19</b>   |  |  |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | <b>20a. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  |  |  | <b>20f. (City or town)</b> (County) (State)         |  |   |  |   |  |                                |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>7-7-</b> <b>1961</b> , to <b>8-10-</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>8-10-</b> <b>1961</b> , and that death occurred at <b>4:40</b> p.m. from the causes and on the date stated above.   |  |  |  |  |  |   |  |  |  |   |  |   |  |   |  |                                |  |
| <b>22a. SIGNATURE</b><br><b>Charles R Shultz, M.D.</b>   |  |  |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  | <b>22b. DATE SIGNED</b><br><b>8-10-61</b>           |  |   |  |   |  |                                |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><b>Dr. Charles Shultz</b>   |  |  |  |  |  | <b>22d. ADDRESS</b><br><b>Simpsonville, Md.</b>   |  |  |  |   |  |   |  |   |  |                                |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><b>Burial</b>  |  |  |  | <b>23b. DATE THEREOF</b><br><b>8/12/61</b>   |  |   |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>Mt. Olivet Cemetery</b>  |  |   |  | <b>23d. LOCATION</b> (City, town or county) (State)<br><b>Frederick, Maryland</b> |  |   |  |                                |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>Robert A. Pumphrey,</b>  |  |  |  |  |  | ADDRESS<br><b>Bethesda, Maryland</b>  |  |  |  | <b>25a. REC'D BY REGISTRAR</b><br><b>AUG 14 '61</b> |  |   |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><b>Arthur L. Hume</b>                        |  |                                |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60



Serial

8/12/61

Mr. Oliver Combs

Director, Kentucky

Robert A. Humphrey, Bethesda, Maryland

and

Mr. Charles Smith

Charles R. Smith, Jr.

X

Respectfully,

*[Faint, illegible handwritten text]*

Yours

Very truly

Respectfully,

Bob A. Smith

John

Smith, Maryland

2 copies

Bethesda, Md.

cc:

1000

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be recorded within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |  |  |   |   |  |
|---|--|--|--|---|--|--|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  |  |  |  |   |  |  |   |   |  |
| 9418 CERTIFICATE OF DEATH 09410   |  |  |  |   |  |  |   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> MARYLAND   |  |  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> |  |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Silver Springs, Md</b>   |  |  |  |   | c. LENGTH OF STAY IN lb<br><b>10 Days</b>  |  |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Alethia Nursing Home</b>   |  |  |  |   | d. STREET ADDRESS<br><b>7006 Wake Forest Drive</b>   |  |   |   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |   |  |  |   |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Nellie</b> Middle <b>Latimer</b> Last <b>Wilson</b>  |  |  |  |   | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>12,</b> Year <b>19 61-</b>  |  |   |   |  |
| 5. SEX<br><b>female</b>   |  | 6. COLOR OR RACE<br><b>white</b>                     |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Aug 12, 1875</b>                                  |   | 9. AGE (In years lost birthday) yrs.<br><b>86</b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>Ohio</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>                             |   |   |  |
| 13. FATHER'S NAME<br><b>John W Latimer</b>  |  |  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Eleanor Sheffield</b>   |  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |  | 16. SOCIAL SECURITY NO.<br><b>none</b>               |  | 17. INFORMANT<br>Address<br><b>Mrs Ralph Hodgson College Park, Md.</b>  |  |  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)<br><b>4-34-1 acute congestive heart failure</b><br>DUE TO (b) <b>arterio-sclerotic cardiac</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>vascular disease</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |   |  |  |   |   |  |
| MEDICAL CERTIFICATION<br>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b><br>20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)<br>21. I certify that (I) (this hospital) attended the deceased from <b>1959</b> 19 <b>Aug 3</b> 19 <b>61</b> , to <b>Aug 12</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Aug 3</b> 19 <b>61</b> , and that death occurred at <b>11:59</b> M, from the causes and on the date stated above.<br>22a. SIGNATURE <b>W.L. Etienne</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/><br>22c. PHYSICIAN'S NAME (Type) <b>W.L. ETIENNE</b> 22d. ADDRESS <b>4713 Chevy Chase Dr NW</b><br>22b. DATE SIGNED <b>8-12-61</b> |  |  |  |   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>Aug 15, 1961</b>             |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   |  | 23d. LOCATION (City, town, or county) (State)<br><b>Chicago Illinois</b> |   |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>F. Gasch's Sons</b>  |  |  |  |   | ADDRESS<br><b>Hyattsville, Md.</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>Aug 15 '61</b> |   |  |
|   |  |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles E. Brown</b>  |  |   |   |  |

ARTICLE OF AGREEMENT

1918

THE UNITED STATES OF AMERICA  
DO hereby certify that the following  
is a true and correct copy of the  
original as the same appears on the  
records of the Department of Health  
and Human Services.  
WITNESSED my hand and the seal of the  
Department of Health and Human Services  
this 1st day of January, 1918.  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be retained by the hospital or attending physician. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
9419 CERTIFICATE OF DEATH 09411

|   |  |  |  |   |  |                                  |  |   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|----------------------------------|--|---|--|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Montgomery</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Bethesda</b><br>c. LENGTH OF STAY IN 1b<br><b>55 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>The Clinical Center, Bethesda 14, Md.</b> |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>STATE<br><b>Virginia</b><br>b. COUNTY<br><b>Carroll</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Hillsville</b><br>d. STREET ADDRESS<br><b>Route # 4</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                  |  |   |  |  |  |   |  |   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Roger</b><br>First<br><b>Marion</b><br>Middle<br><b>Worrell</b><br>Last  |  | 4. DATE OF DEATH<br><b>August</b><br>Month<br><b>13</b><br>Day<br><b>19</b><br>Year<br><b>61</b> |  | 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>December 19, 1940</b> |  | 9. AGE (In years last birthday)<br><b>20</b> yrs.                         |  | 10. IF UNDER 1 YEAR<br>Months<br><b>11</b><br>Days<br><b>11</b> |  | 11. IF UNDER 24 HRS.<br>Hours<br><b>11</b><br>Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Student</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |  |                                  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Ohio</b>  |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                             |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>Blaine Worrell</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Thelma Dee Edwards</b>   |  |                                  |  |   |  |  |  |   |  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>Yes</b><br><b>1960 - 1961</b>   |  |  |  | 16. SOCIAL SECURITY NO.<br><b>229-50-9794</b>   |  |                                  |  | 17. INFORMANT<br><b>The Medical Record</b><br><b>The Clinical Center, Bethesda 14, Maryland</b>   |  |  |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>Staphylococcal cellulitis</b><br>IMMEDIATE CAUSE (a)<br><b>591X</b><br>DUE TO<br><b>Nephrotic syndrome</b><br>(b)<br>DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>11 months</b>             |  |  |  |   |  |                                  |  |   |  |  |  |   |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br><b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |  |                                  |  |   |  |  |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)   |  |                                  |  |   |  |  |  |   |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>   |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |                                  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |  |  | 20f. (City or town) (County) (State)                                      |  |   |  |  |  |
| 21. I certify that <b>OK</b> (this hospital) attended the deceased from <b>June 19, 1961</b> to <b>August 13, 1961</b> , that <b>we</b> last saw the deceased alive on <b>August 13, 1961</b> , and that death occurred at <b>6:40PM</b> from the causes and on the date stated above.  |  |  |  |   |  |                                  |  |   |  |  |  |   |  |   |  |  |  |
| 22a. SIGNATURE<br><b>Richard Adler, M.D.</b><br>M.D.  |  |  |  |   |  |                                  |  | 22b. DATE SIGNED<br><b>8/14/61</b>  |  |  |  |   |  |   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Richard Adler, M.D.</b>  |  |  |  |   |  |                                  |  | 22d. ADDRESS<br><b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>   |  |  |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  |  | 23b. DATE THEREOF<br><b>8/14/61</b>   |  |                                  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mona Vista Mem. Gardens</b>  |  |  |  | 23d. LOCATION (City, town or county) (State)<br><b>Carroll Count, Va.</b> |  |   |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Robert A. Humphrey</b><br>ADDRESS<br><b>Bethesda, Maryland</b>   |  |  |  |   |  |                                  |  | 25a. REC'D BY REGISTRAR<br><b>AUG 18 '61</b><br>DATE  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles L. Hanna</b>                     |  |   |  |  |  |

1942

(M)

Home

Virginia

University

Williamsburg

12 days

February

March 4

March 12

The Clinical Center, Williamsburg, Va.

Warrenton

March 12

Warrenton

December 12, 1940

White

White

Ohio

Ohio

Warrenton

March 12, 1941

Warrenton

222-50-778 The Clinical Center, Williamsburg, Virginia

1940 - 1941

Warrenton

Staphylococcus aureus

3 days

11 months

Warrenton

June 12, 1941

June 12, 1941

1941

x

The Clinical Center, Williamsburg, Virginia

Warrenton, N.D.

From Virginia State

Report to the Warrenton, N.D. and the Williamsburg, Virginia



TO HOSPITAL: The law requires that death certificates be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if event, within 72 hours after death.

M

I

MEDICAL CERTIFICATION

1

BP

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                                     |  |   |  |   |  |  |   |   |  |
|---|--|-------------------------------------|--|---|--|---|--|--|---|---|--|
| CERTIFICATE OF DEATH  |  |                                     |  |   |  |   |  |  |   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>  |  |                                     |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> |  |  |   |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Olney</b>  |  |                                     |  | c. LENGTH OF STAY in 1b<br><b>41 days</b>   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Derwood</b>  |  |  |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Montgomery General Hospital</b>  |  |                                     |  |   |  | d. STREET ADDRESS<br><b>RFD #1</b>  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Ruth</b> Middle <b>Felicia</b> Last <b>Zebuhr</b>  |  |                                     |  |   |  | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>26</b> Year <b>1961</b>  |  |  |   |   |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>    |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Feb. 6, 1927</b>   |  | 9. AGE (In years last birthday)<br><b>34 yrs.</b>    |   | IF UNDER 1 YEAR<br>Months <b></b> Days <b></b> Hours <b></b> Min. <b></b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House Wife</b>  |  |                                     |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |   |  |
| 13. FATHER'S NAME<br><b>Harry Tyson Bussard</b>   |  |                                     |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Catherine Lawson</b>  |  |  |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)  |  |                                     |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMATION<br>Address <b>Medical Records</b>   |  |  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Malignant Melanoma (Generalized)</b><br><b>1908</b> <b>due to</b> <b>metastasis to lungs, brain and lymph nodes</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>and both breasts.</b><br><b>due to</b> |  |                                     |  |   |  |   |  |  |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |                                     |  |   |  |   |  |  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                     |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |  |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b></b>   |  |                                     |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)<br><b>Gaithersburg, RFD</b>      |   | (County) <b></b> (State) <b></b>  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 9, 1960</b> to <b>Aug. 26, 1961</b> , that (I) (we) last saw the deceased alive on <b>Aug. 25, 1961</b> , and that death occurred at <b>12 AM</b> , from the causes and on the date stated above.   |  |                                     |  |   |  |   |  |  |   |   |  |
| 22a. SIGNATURE<br><b>Jack Schumacher</b> M.D.   |  |                                     |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>               |  |  | 22b. DATE SIGNED<br><b>Aug. 26, 1961</b>  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Jack Schumacher</b>  |  |                                     |  |   |  | 22d. ADDRESS<br><b>Gaithersburg, Maryland</b>   |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>8-29-61</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Rose</b>   |  | 23d. LOCATION (City, town or county)<br><b>Gaithersburg, RFD</b>  |  | (State) <b></b>                                      |   |   |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>Ernest C. Gartner. Gaithersburg. Md.</b>   |  |                                     |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>AUG 29 '61</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kress</b> |   |   |  |

0288

0280

(M)

— and both parties  
— interested to keep things  
— (separate) *William*